United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

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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. Substantial Compliance Ratings and Progress

Across the State's 13 Facilities, there is variability in the progress being made by each Facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation of the parties who crafted the Settlement Agreement was for the State to make systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the Facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a Facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report to identify the Facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the Facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity. Some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, Section L.1 addresses the total system of the provision of medical care at the Facility. This is in contrast with Section T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each Facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the Facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement. This is due to the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the Facility (as was the intent of the parties).

V. Executive Summary

During this most recent review, it continued to be evident that LBSSLC had taken many steps to address issues that had been identified during previous reviews, and to comply with the Settlement Agreement. As was discussed during the onsite review, with some of the more complex portions of the Settlement Agreement, change will take a while, so methodical and steady progress is what will ultimately result in success, and sustained change. At LBSSLC, a number of key steps had been taken and the infrastructure was being built. The change that was occurring was meaningful change that was resulting in improved supports for the individuals living at LBSSLC.

As indicated in the last report, the importance cannot be overstated of LBSSLC's improved ability 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 again through the interdisciplinary and collaborative discussions during the Quality Assurance/Quality Improvement meetings, as well as throughout many facets of the organization.

At this point in the life of the Settlement Agreement, the challenge for the Lubbock team is to grow some of the systems for which the foundations have been built, but that still require full development and implementation, as well as to address some of the areas for which adequate progress had not yet been made. 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 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

- As stated in previous reports, there was clear evidence that LBSSLC had worked diligently to monitor and evaluate the use of restraint, and to design and implement alternative interventions. During the Monitoring Team's onsite visit, it was again noted that the use of restraint had been effectively replaced for some individuals by more individualized and less restrictive approaches in the residential and programmatic areas of the Facility. At the same time, however, numerous opportunities were observed where the Facility failed to ensure that individuals' Positive Behavior Support Plans adequately addressed their needs and that they were implemented consistently. Teams did not consistently address individuals' environmental, adaptive skills, and biological, medical, psychosocial issues that potentially led to restraint.
- The Facility leadership and staff were to be commended for their vigorous efforts to ensure that training requirements were fully met. At the time of the site visit, all employees who were required to be trained in the appropriate use of restraint had met this expectation.
- Furthermore, the review of incident investigations confirmed that improper restraint would not be tolerated. Disciplinary action (dismissal) was taken against employees who used prone restraint and who failed to comply with the mandates of the Do Not Restrain List. This single brief episode of improper restraint resulted in

additional staff training, and in an enhanced effort to alert staff to individuals who cannot be restrained because of medical or psychological reasons.

- Despite the continued efforts and progress described above, 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. Since the Monitoring Team's last visit, the Chief Nurse Executive and the Director of Behavioral Services attempted to remediate this problem by redesigning the protocol for notification of nursing personnel. The effect of this new method of alerting nurses to the need to respond promptly to an episode of restraint will be evaluated during the next site visit.

Abuse, Neglect and Incident Management

- The Facility's commitment to zero tolerance of abuse, neglect and exploitation, as well as the complete and timely investigation of serious incidents is both 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 and employee training and the more timely submission of investigations. It was significant that improper restraint use was investigated and determined to be physical abuse. The Facility provided evidence that abuse resulted in appropriate disciplinary action including termination from employment. In general, investigation reports continued to comply with the standardized format. However, concerns were noted with regard to DFPS and Facility investigators' review of the previous history of alleged perpetrators.
- Since the Monitoring Team's last site visit, the Facility Director had appointed an Incident Management Coordinator. He had begun to develop methods for the tracking and analysis of data. This work, in combination with that of the Risk Manager and the Director of Behavioral Services, had contributed to a greater understanding of the nature of serious incidents and allegations. Although it was recognized that additional work was necessary, this was a very positive step.
- The Facility's strenuous efforts to ensure that employees were fully trained in the requirements for the reporting of abuse, neglect, and exploitation was recognized and applauded by the Monitoring Team.
- Although significant work must be completed before Section D can be in full compliance with the obligations of the Settlement Agreement, the Facility continued to make substantial progress. The Facility should focus additional time and attention on the development and implementation of accurate databases; the analysis of trends by individual and by residential unit; the identification and replication of positive practices that have eliminated injuries and other serious incidents; expanded opportunities for individuals to exercise meaningful choice and thus avoid confrontations with staff; and additional training and/or supervision for Facility investigators so that their investigative skills can be further enhanced and the findings of their investigative reports strengthened.

Quality Assurance

- Since the Monitoring Team's last visit, the Facility had taken significant actions to strengthen the Quality Assurance (QA) process. Clearly, the design and implementation of an effective and sustainable Quality

Assurance process was a priority. There was a notable commitment to utilize appropriate and effective monitoring and evaluation strategies in achieving compliance with the outcomes of the Settlement Agreement.

- It was apparent that the Quality Assurance/Quality Improvement (QA/QI) Council had become a relied-upon partner in the efforts to reach compliance with the requirements articulated in Section E. Data regarding injuries, incidents and restraint use were discussed routinely at the Council meetings. Subcommittees were formed to address particular concerns. Corrective Action Plans (CAPs) were identified and tracked. A second direct support professional had been added to the Council to ensure needed input from and outreach to the staff working closest to the individuals residing at LBSSLC.
- Monthly monitoring was conducted in a collaborative manner between the clinical/professional departments and the Quality Assurance staff. The Facility continued to need to make improvements to the monitoring system. For example, inter-rater reliability continued to be inconsistent, and instructions setting forth the methodologies and standards for monitoring and evaluation continued to need to be refined.
- Some of the current monitoring activities were successful in assisting the Facility to identify areas requiring improvements. However, although the monthly monitoring results provided useful information, more detailed analysis of the monitoring conducted by the Departments and by the Quality Assurance staff would be helpful in evaluating areas in which the Facility had made progress, and areas still needing improvement. The QA/QI 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.
- The development and implementation of a strengthened process for addressing programmatic and environmental deficiencies continued to evolve. Seven CAPs were being tracked at the time of the site visit. In addition, nine workgroups had been established to address/improve recurrent systems. The CAP Tracking Log had been revised to include the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task.
- Since the Monitoring Team's last onsite review, data collection and analysis had become more detailed. Discussions about the data were noted in several forums, including the QA/QI Council, the Incident Management Review Team meetings, and the Executive Safety Committee. The newly appointed Incident Management Coordinator had made substantial effort to aggregate facts about incidents and incident investigations, and was beginning to develop reliable reports on trends. The information the Director of Behavioral Services, the Risk Manager and the Incident Management Coordinator now collected would benefit from a coordinated approach to the analysis and discussion of the facts about restraint use, injuries, and serious reportable incidents.
- The Facility had expended considerable effort in its ongoing plans to develop and track key indicators and outcome measures. This initiative will continue to require close collaboration between the clinical/professional Departments and the Quality Assurance staff. It was the Monitoring Team's assessment that the Facility had identified data that was being or could be collected. This was an important first step in this process. However, actual key indicators and/or outcome measures had not yet been developed. In order for this to occur, the data

needed to be linked to the Facility's programmatic goals, such as health, safety, and meaningful lives for the individuals who reside at LBSSLC. Then, the Facility needed to set goals and collect data to determine if such goals were being met. Part of this process would be the establishment of baseline data and benchmarks. As this system is developed, it will be important to ensure that it includes measures and strategies for qualitative evaluation of the progress individuals who reside at the Facility make. As the Facility continues its efforts to finalize these outcome measures, the Monitoring Team recommends an incremental approach to implementation so that any necessary adjustments can be made effectively and in a timely manner.

- 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.

<u>Integrated Protections, Services, Treatments and Supports</u>

- Since the last review, the Facility had taken additional positive steps to assist Qualified Developmental Disability Professionals (QDDPs) in developing their meeting facilitation skills. These included:
  - The QDDP Educator had worked with a number of staff throughout the Facility to develop an On-the-Job (OJT) training curriculum for QDDPs. Based on the information provided, it appeared that the training should assist in providing new QDDPs with a solid foundation with regard to the various disciplines, as well as the requirements for a QDDP.
  - In addition, the QDDP Coordinator had set up a Facilitation Buddy Program. QDDPs were paired with one another, and each attended the other's meetings. The intent of this program was to provide QDDPs with weaker facilitation skills with the opportunity to observe meetings at which stronger facilitation occurred. In addition, by having another QDDP take notes, it was hoped that the notes from the meeting would improve, because QDDPs, as opposed to clerks, understood better what was relevant for the final Individual Support Plan (ISP) document.
- Based on the meetings observed while the Monitoring Team was onsite as well as review of ISP documents, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and, to a limited extent, a more person-centered focus. Some incremental positive changes were being seen in the ISP documents. For example, the Facility was clearly making efforts to broaden the scope of action plans included in individuals' ISPs, and to better define the roles of direct support professionals. However, as described in greater detail below, the Facility had much work left to do to ensure that ISPs set forth comprehensive plans with adequate indicators and measures to ensure that individuals received the protections, supports and services that they needed, and, most importantly that the efficacy of such supports and interventions were measured, and changes were made as necessary.
- Some areas that required attention included:
  - As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition, vocational assessments, and physical and nutritional supports. Updated medical assessments

often were not available at the time of the ISP meeting. Adequate assessments are the foundation for good individualized planning, and this foundation was not yet in place at LBSSLC.
    - Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen.
    - Action plans had been broadened in scope. For example, the risk action plans had now been incorporated into the ISP document. However, these supports were not well defined, generally did not have measurable objectives or outcomes associated with them, and provided little description of the methodologies that would be employed to realize the objectives. Many other supports, services, treatments, or strategies were not addressed in the ISPs. For example, ISPs provided little definition of day and vocational supports, communication and other therapy supports, the full scope of nursing care plans, or medical and psychiatric treatment plans. Focused effort was needed to improve the scope of action plans, as well as to ensure measurable outcomes/objectives, and clear methodologies were included.
    - The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.
- Although it was positive that monthly reviews were now being completed and documented in the Integrated Progress Notes, they did not cover the full scope of ISP activities. 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, but this was not evident in the current monthly reviews. The QDDP reviews provided brief summaries of individuals' progress on their skill acquisition programs, and a summary of medical occurrences. To close the loop, however, the QDDP would need to review other team members' monthly reviews and take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified.

<u>Integrated Clinical Services</u>

- Although improvements were still needed, some level of integrated care took place through a variety of committees that were the forums for interdisciplinary discussion, including the Medication Safety and Systems Committee, the morning provider meeting, the Physical and Nutritional Management Team, and the IDTs.
- The morning provider meeting provided an integrated approach to clinical care on campus. During this meeting, nurses attending the meetings later communicated concerns to the QDDP. Reportedly, if needed, the QDDP would call an IDT meeting to address the concern, and if necessary, held an ISPA addendum meeting. If there were a health status change, the ISPA was supposed to reflect action steps and a change in risk rating. The nurse

from the PNMT also attended the morning provider meeting. The morning provider meeting included a review of hospitalized individuals by the Hospital Liaison Nurse.

- Community consultant reports also were read at this committee, and reportedly, this information was subsequently discussed at IDT meetings. However, based on the Monitoring Team's review of related documentation, teams were not reviewing consultant reports and related PCP recommendations, and/or documenting this discussion and the teams' decisions. Significant improvement was needed in documentation of the IDT review of consult reports and follow-up.
- Although improvements were seen in the morning medical meeting, all clinical departments are essential in providing integrated clinical care. The Facility had begun to identify data it was collecting, but it had not developed a set of measurable indicators for each department that reflected the integration of care across the campus. For example, measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. Similarly, there is considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the integrated risk discussion results, the risk action plans, the implementation steps taken, and the outcomes. However, the Facility had not yet begun to define these indicators.

<u>Minimum Common Elements of Clinical Care</u>

- Routine periodic reviews were essential to the care of those residing at LBSSLC. However, the Facility still struggled with completing annual medical evaluations in a timely manner. The timely completion of quality medical quarterly progress notes could not be confirmed through the records submitted.
- In addition, this section is interdisciplinary, and the Facility should submit evidence of timely assessments and treatment across all of the clinical disciplines. Providing evidence of required common clinical elements of care for both acute and chronic illness remained a challenge to the Facility.
- Medical response to acute care needs appeared to be appropriate. However, there were concerns related to direct support professionals and nursing staff's lack of recognition of change in individuals' health status, as well as nursing staff's lack of timely assessment, with applicable documentation.
- The State Office clinical guidelines recently had been implemented. Additionally, the external medical peer review, with its medical management component, offered further guidance with regard to choice of clinical indicators and measurement tools for quality medical care. However, the Facility did not yet have a system to capture information related to these clinical indicators or routinely use such information to improve services provided.

<u>At-Risk Individuals</u>

- The Facility appointed a new leader for this section. A working group was convened to determine the future direction. A set of questions and document references were created to assist the teams in providing justification for each risk category. The Facility determined that little evidence was available in the active records to show that teams met the five-day timeframe for beginning the assessment process according to the needs of the

individual, and the 14-day period for implementation of the plan. This was consistent with the findings of the Monitoring Team.

- A review of the risk process indicated a wide variation in quality. Some IDTs used the Integrated Risk Rating Form, while other teams used the Integrated Risk Discussion Results form. In addition, there were inconsistencies regarding the Risk Action Plans being placed in the ISP. However when they were, they were difficult to find at times. This would appear to have created a barrier to their use.
- The newest risk screening documents had considerably improved justification, but these also were found to be inconsistent. Regarding the Risk Action Plans, little improvement was found regarding the quality of the plans. An additional concern was the lack of follow-up to ensure the plan was actually being implemented. Also of mounting concern was the fact that during every review, major pieces of the At Risk process were under construction rendering it difficult to identify the exact clinical interventions and when they were provided to the individuals.

<u>Psychiatric Care and Services</u>

- The Facility had added a new full-time locum tenens Psychiatrist. The Director of Psychiatry had performed a time analysis, and concluded that two full-time Psychiatrists should be sufficient to provide services to the 126 individuals prescribed psychotropic medication at LBSSLC. This analysis also took into account the support staff, which included a Psychiatric Assistant and a newly added Psychiatric Clerk. The current full-time Psychiatrists were both Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, and the part-time Consulting Psychiatrist, who was on site for four hours per week, was Board Certified in Child Psychiatry by the American Board of Psychiatry and Neurology.
- The Psychiatry Department had revised the content of the Comprehensive Psychiatric Assessments (CPA) to better conform to the requirements of the Settlement Agreement. The Facility reported that these had been completed for over 50 percent of the individuals who received psychotropic medications. With two full-time Psychiatrists, and the Consulting Psychiatrist continuing on four hours per week to assist with the CPAs, it was anticipated that the Facility would complete these within the next six to 12 months, for all of the individuals who receive psychotropic medication, and then maintain the process of annual updates in conjunction with the individuals' ISP reviews.
- On 3/12/12, a member of the Monitoring Team attended the Desensitization Committee Meeting. Representatives from the Psychiatry, Psychology, Dental, Medicine, and Nursing Departments, as well as the QDDP Educator and others attended this meeting. The discussion was quite detailed, and it was clear that the effort to address Section J.4 was now actively in process.
- The Facility also had developed a policy to identify individuals who could benefit from a Reiss Screening Assessment, and there was documentation that indicated this new policy was being followed. The Psychology Department was launching a previously delayed initiative that would include the administration of the Reiss

Screen to the individuals who were not receiving psychotropic medication and who had not been screened in several years. This was to occur in the context of a complete psychological assessment.

- The Psychiatrists had begun to attend the ISP meetings, and, now, with the two Psychiatrists available, it should be possible to do this on a regular basis. During the onsite review, a member of the Monitoring Team was able to attend the ISP meeting of an individual and the individual's Psychiatrist was an active participant. The review of the documentation from an earlier ISP that the Psychiatrist had attended indicated that some of the contributions from psychiatry were included under the medical section and others under the psychology section. It will be important that the psychiatric contributions are clearly indicated in the final ISP documentation, including their integration with other disciplines.
- Another issue related to documentation had been the dual identification of target behaviors of the psychotropic medications, such as aggression or self-injury, as also being present on a learned basis, which gave the impression that the medication was being used to suppress a learned behavior. In many individuals, the behavior was, of course, determined by both factors. The Psychiatry Department had responded to this with thorough discussions in the CPAs and elsewhere in the records, and the Psychology Department had now added a discussion that addressed this in the Functional Analysis.
- Progress regarding reductions in polypharmacy continued. The Psychiatry Department had created three sub-categories that were derived from comments made in the Monitoring Team's previous reports. The two primary categories were "Active" to denote those individuals that the Department was still making ongoing efforts to decrease one or more of the current psychotropic medications, and "Stable" for those individuals who were felt to require their existing medication to maintain their continued stability. The importance of assembling as much empirical evidence as possible to document the efficacy of these medications, and, thus, justify their continued utilization was discussed during the onsite review with the Psychiatry Department team, and is expanded upon in this report. The Department was considering enlisting the help of their new clerk in assembling this data. The third category, which was labeled: "New Admissions," tracked the progress of the individuals who had been admitted from the community on multiple psychotropic medications. The Monitoring Team was able to follow three of these individuals longitudinally over the past year in the observations of the Psychiatric Clinics, and their progress had been remarkable.

<u>Psychological Care and Services</u>

- Progress was noted in regard to psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing including the continued completion of necessary coursework and required supervision. Recently, one psychologist had passed the BCBA exam and was promoted to Assistant Director. In addition, internal and supplemental external peer review continued to demonstrate improvement. The collaboration between LBSSLC and Texas Tech University had evidenced positive outcomes, including improved accessibility of data collection systems, in addition to contributing to critical peer review.

- Similar improvement was noted in the development of more comprehensive Monthly Positive Behavior Support Plan (PBSP) Progress Notes, including graphic data display. However, inconsistencies between displayed data and PBSPs, as well as concerns with the timeliness and adequacy of review were noted in some cases. In addition, summary and analysis of Inter-observer Agreement (IOA) data continued to be lacking.
- Although psychological assessments were completed or updated annually, most remained inadequate due to outdated standardized tests of intelligence and adaptive behavior. However, recent re-adjustment of staff responsibilities will likely support improved completion of these standardized assessments. Review of Structural and Functional Assessment Reports (SFAR) noted continued improvement and found those sampled to be adequate. Recently, the development of a self-monitoring tool, as well as a change in format likely will assist psychologists in maintaining the quality of SFARs.
- Progress was noted in the provision and monitoring of psychological services as initial improvements in counseling treatment plans was noted. In addition, continued improvement in the quality of PBSPs was observed. A qualitative change in the format of PBSPs that was currently underway appeared likely to offer enhanced accessibility as well as utility in the assessment of treatment integrity. Limited progress was noted, however, in developing procedures and methods to ensure that staff received competency-based training.

<u>Medical Care</u>

- The Medical Department had a complex, but user-friendly medical database system. From this data, the Department was able to track ER visits and hospitalizations, determine trends, investigate causes, and implement plans that had positive impact on quality medical care at LBSSLC. This was an important piece of a medical quality review system. However, problems with the validity of data were noted when compared with other data submitted to the Monitoring Team. In addition, the Facility had not yet utilized the clinical guidelines to develop measures of treatment quality across the variety of conditions individuals experienced.
- The morning provider meeting continued to be a forum for integrated medical care management. There was a consistent interdepartmental presence. The meeting continued to be the conduit for reporting health status change to the QDDP by way of the Nursing Department representative at the morning meeting. Closure was tracked via a worksheet. However, although some discussion occurred at morning meetings regarding closure, it was unclear how this information was routinely reconciled. Concerns routed to the QDDP and then to the IDT also were not tracked to determine if the team met, as appropriate, and when necessary, an ISPA was created and implemented.
- In addition, there was a continued need for the group to focus on preventing recurrent hospitalizations and adverse events.
- The Monitoring Team's review identified problems with the timely completion of annual assessments and evaluations, as well as the completion of quarterly reviews. In addition, based on data the Facility provided, some of the preventative evaluations (e.g., mammography, vision, and audiological screening) were not being completed timely and consistently for individuals.

- LBSSLC did not have an adequate system in place to track the reasons for missed appointments, and address the underlying causes. Some of these appeared to be systems issues, while others would require individuals' IDT to be involved in addressing the issues.
- Those individuals with a DNR status needing annual renewal appeared to be up-to-date in most cases.
- The external and internal peer review processes were completed together. Unfortunately, the data could not be separated. A new area the audit covered was medical management of select diagnoses. This was included in the February 2012 external review. However, a synopsis of the February audit was not available. The QA Department tracked the corrective action plans of prior audits to completion. A few incomplete corrective action plans remained.
- Although the Facility was up-to-date on its clinical death reviews, no information was available to confirm implementation of the recommendations from the various types of death reviews. In fact, it was not clear that the Facility had a process in place to determine agreement on the death review recommendations, and then ensure adequate follow-through occurred.

<u>Nursing Care</u>

- Since the last review, LBSSLC had some changes in its Nursing Department and nursing positions, which included filling the newly established position for the Case Manager Supervisor, and experiencing some turnover in the Registered Nurse (RN) positions. In addition, the Nursing Department had a total of 96 allotted positions for nurses. Nursing vacancies included seven RN position, and five Licensed Vocational Nurse (LVN) positions. Although the Nursing Department had experienced some degree of nursing turnover, the Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions.
- Some of the Facility's positive steps forward included:
    - In November 2011, the QA Nurses and the Nursing Department reduced the number of monitoring tools completed each month in an effort to focus on areas of greatest need. These areas included Medication and Documentation, Urgent Care and Hospitalizations, Annual and Quarterly Nursing Assessments, Documentation, Nursing Care Plans, and Infection Control (IC).
    - In January 2012, the QA Nurses and the Chief Nurse Executive (CNE) began meeting monthly to discuss monitoring activities.
    - Although not formally integrated into the instructions of the monitoring tools yet, the QA Nurse had begun to use the nursing protocols when auditing the nursing documentation in effort to address the quality of the nursing documentation.
    - The construction and data entry regarding the Facility's immunization database was completed.
    - In January 2012, the IC Nurse and a QA Nurse implemented a Real Time Audit for Acute Infections. This audit identified some important areas requiring attention.
    - The Facility implemented the Medical Emergency Response Drills Weekly Report that summarized relevant data regarding the drills conducted for the week.

- The Facility had continued to conduct drills in alignment with the Facility policy, and had added the areas of Food Service and Maintenance to the drill schedule.
- In an attempt to decrease the number of unexplained medications returned to the pharmacy, the Facility initiated a pilot program that consisted of separating the seven-day refilled medications by shifts to reduce the number of medications that were contained in one medication drawer. Due to the success of this pilot, this system was expanded to other residences.
- The Facility initiated the weekly monitoring of the Medication Administration Records (MAR) by the RN Unit Managers due to the large number of MAR blanks left unsigned by the nurses administering medications. The Facility data indicated that from December 2011, to January 2012, the number of MAR blanks had decreased by 219 to 21, a 91% reduction.
- In effort to decrease medication variances related to medications being given to the wrong individual, at the time of the review, the Facility was in the process of implementing a very promising pilot project using an identification card for each individual. Direct support professionals would present it to the nurse for comparison to the individual's picture on the MAR as an additional safety step to ensure the right individual was receiving the right medications.

- Although the Facility had made some positive steps in the areas noted above, of most concern was the lack of overall progress made in critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in health status, the quality of the quarterly/annual comprehensive nursing assessments, and the nursing documentation regarding individuals who transitioned into the community. These findings were consistent with the findings from the past four reviews, and no specific plan appeared to be in place to address these critical areas.
- In addition, although some promising steps forward were made regarding the Facility's medication administration system, at the time of the review, a number of significant problematic issues continued to exist, such as unexplained medications returned to the Pharmacy indicating that a number of doses were not administrated as ordered, underreporting of medication variances, and the lack of integration of the physical nutritional management plans into the administration of medications.

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

- Based on the review of submitted documents, the pharmacy processed new orders with attention to drug-to-drug interactions, side effects, allergies, lab results and monitoring, and dosage adjustments. However, medication use with individuals with Jejunostomy Tubes (J-tubes) appeared to be an area needing further review.
- The pharmacy was not receiving all the chemical restraint forms for review and comment. The comment section had improved, but there was need for additional information.
- The QDRRs were of high quality and were inclusive of many of the topics listed in Section N.
- The drug utilization evaluations were completed in a timely manner.

- Adverse drug reaction (ADR) training needed to continue, particularly for nursing staff, who would play an essential role in the identification and reporting of ADRs.
- The pharmacy had made several in-roads into reducing medication variances on campus. Significant challenges remained, but the department had collaborated with nursing to continue to improve the safety of the system.

Physical and Nutritional Supports

- During the Monitoring Team's last onsite review, the Physical and Nutritional Management Team (PNMT) core members were an Occupational Therapist (OT), Speech Language Pathologist (SLP), Physical Therapist (PT), Registered Nurse (RN), Registered Dietician (RD), and Clerk. The former PNMT PT had resigned. In the absence of a PT, the Director of Habilitation Therapies (HT) assigned the Facility Physical Therapy Assistant (PTA) as a new member of the PNMT. However, a PTA did not meet the Settlement Agreement requirement that the PNMT have a physical therapist.
- Since the last review, it was positive the Facility had continued to further define the responsibilities of the PNMT and the IDT members. These revisions included definitions of: PNMT roles at the hospital, responsibilities of the PNMT Clerk, role of the IDT, referral to the PNMT, PNMT self-referral, PNMT timeline to respond to a referral, PNMT timeline for implementation of an action plan, and the PNMT process for an individual's return to the IDT. The revisions were appropriate and provided a relevant expansion of responsibilities for PNMT and IDT members. However, the Monitoring Team has recommended some additions to the guidelines to ensure they comprehensively address the various roles and responsibilities.
- The PNMT had met with the Facility Director to "present systemic issues." It was positive that the PNMT members were bringing these issues forward and working with the Facility Director to seek resolution. However, no documentation of follow-up meetings was submitted, and/or information about the progress toward resolution of the identified issues/concerns.
- A list of 218 individuals identified 170 individuals as having physical and nutritional management (PNM) needs, and 48 individuals without PNM needs. However, a review the 48 individuals without PNM needs and their PNM risk rating rankings identified some individuals that appeared to have PNM needs.
- The Physical and Nutritional Management Plan (PNMP) and dining plan format had been revised. The PNMP and dining plan format revisions reflected positive changes from the previous templates. Based on interview with the Director of HT, by October 1, 2012, all individuals' PNMPs and dining plans would be revised. In addition, the Director of HT stated that the revision of PNMPs would provide the opportunity to provide competency-based training and performance check-offs for veteran staff in core PNM competencies.
- A review of staff instructions in individuals' PNMPs noted improvement in the areas of wheelchair and alternate positioning, time an individual was to remain upright after a meal, bathing/showering, medication administration, and oral care.
- Recommendations made in the previous report for instructional content to support the attainment of mealtime foundational knowledge and skills had been incorporated into the Mealtime Coordinator (MTC), Feeding and

Mealtime Management, and Nutrition Services training curricula. This was a significant positive advancement in the provision of adequate MTC training to support safety at mealtimes. The Monitoring Team observed the presence of Mealtime Coordinators in dining rooms during meal observations. Although their performance varied, overall, improvements were noted. In the previous report, the score for staff's compliance with dining plans during mealtime observations was 27%. During this review, the compliance score had increased to 73%, resulting in a significant improvement.

- Based on interview with the Director of HT, in November 2011, the therapists had initiated a review of the New Employee Orientation (NEO) curriculum to establish which PNM skills would require staff demonstration. This review produced the development of six PNM competency performance check-offs. This was a positive move forward in requiring new employees to complete performance check-offs to test their competency with learned skills. The Facility acknowledged that veteran staff would need to complete these core PNM competency performance check-offs. At the time of the review, the Director of HT was beginning the process of developing a training plan with Unit Managers.
- Adequate systems were not yet in place for monitoring either staff's compliance with or the effectiveness of individuals' PNMPs, PNMT action plan, and/or risk action plans.

<u>Physical and Occupational Therapy</u>

- At the time of the review, the Facility OTs and PTs used two different formats for assessments: the OT/PT comprehensive assessment format, and an assessment of current status. The Director of HT was in the process of prioritizing individuals and developing a schedule for the completion of the assessment of current status. No Facility policies and/or procedures were available for the completion of these OT/PT assessment formats. In addition, the assessment formats did not provide guidelines and/or required content under specific assessment sections.
- Documentation showed that none of the 220 individuals (0%) living at LBSSLC received direct OT and/or PT service programs. At the time of the previous review, 13 individual had received direct therapy. The Facility had experienced some turnover in therapy staff. However, given individuals' needs, it was concerning that no direct therapy was being provided.
- A review of individuals' records noted that some individuals' PNMPs were not current, OTs and PTs did not consistently attend individuals' annual ISP meetings, ISPA meetings were not convened to discuss PNMP changes, and PNMP strategies were not integrated into ISPs within risk action plans, nursing care plans, skill acquisition programs and/or Positive Behavior Support Plans.
- The HT Department did not have a policy and/or procedure to define the requirements for the completion of a comprehensive assessment of prescribed PNMP adaptive/assistive equipment to address fit, availability, function, condition, and effectiveness of the equipment. Individuals' records reviewed did not indicate a comprehensive assessment of their prescribed adaptive/assistive equipment had been completed.

Furthermore, individuals' adaptive/assistive equipment was not monitored on an established schedule for availability, condition and use of adaptive/assistive equipment.

- Based on interview with the Director of HT, she had approved the use of a new Compliance Monitoring form. In December 2011, the therapists initiated the use of the Compliance Monitoring tool. The tool was designed to monitor staff compliance with positioning, meals, snacks, medication administration, oral care, bathing, lifting/transfers, and communication. Copies of the monitoring forms were being provided to the Residential Coordinator and Unit Manager for their review. It was noted that a meeting would be scheduled to discuss action plans and a tracking system to ensure closure for identified issues. At the time of the onsite review, this meeting had not occurred. The Director of HT stated that Compliance Monitoring tool data was being entered into a database. However, no analysis of the Compliance Monitoring form data had been initiated.

<u>Dental Services</u>

- Since the last Monitoring Team's visit, the Dental Department did not make measurable progress. In part, this was due to problems related to lack of access to the old database, and the problems related to the new database, which did not yet include complete information. Consequently, there was little to no computer-generated information. Everything had to be hand calculated, and files had to be manually searched. This created delays in progress in every aspect of dental care.
- A number of important documents appeared to be missing from some of the dental records the Monitoring Team reviewed. This included such documents as the annual examination, periodontal chart, dental sedation plan, current treatment plan, current consent, and a copy of the HRC-approval document. The rate of timely annual examinations was determined to be 65%.
- The annual dental summaries provided important information to the IDT members in lay language. However, many were created based on dental examinations several months earlier, raising the concern that they potentially were no longer accurate due to the length of time from the examination.
- The Dental Department did not make progress on reducing the missed appointment rate.
- The latest oral hygiene scores appeared to be slightly worse than in prior months. The dental hygienist had not been able to provide in-service training in the residences.

<u>Communication</u>

- During the last review, it was reported that no individuals received direct therapy. Similarly, at the time of this most recent review, none of the individuals at LBSSLC received direct therapy from a SLP. The Monitoring Team is hopeful that the addition of a fourth SLP will result in SLPs having additional time to provide direct therapy to individuals to enhance their skills in the use of their AAC system(s).
- SLPs were working in collaboration with psychologists to develop skill acquisition programs for the self-administration of medication. The collaboration between the SLPs and the psychologists demonstrated forward movement toward compliance within this section. However, a review of SLP assessments and PBSPs did not show collaboration between psychologists and SLPs.

- Based on documentation provided, 90 of the 220 (41%) individuals at LBSSLC had an augmentative/alternative communication (AAC) device. However, individuals' Speech Language (SL) assessments completed from 2008 to 2011 were completed prior to the most current revision of the SL assessment template. As a result, these assessments might not have included an AAC comprehensive assessment. It will be necessary for an audit to be completed of individuals' assessments and/or AAC consultations during these years to determine whether or not these individuals' assessments contained a comprehensive AAC assessment.
- An increasing number of individuals had action steps and/or training objectives to develop individuals' skills for functional communication skills with the use of their AAC systems. This was a positive advancement in the integration of individuals' ACC systems into their ISPs.
- The NEO Follow-Up AAC Competency Drill had 11 tasks that required staff demonstration and/or verbal explanation. This drill could be individualized for an individual's AAC system. The demonstration drill met the standard of competency-based training, because it required staff to demonstrate their knowledge and skills. The development and implementation of core communication competencies for new employees was a positive development. However, as the Facility recognized a plan had not yet been developed for the completion of competency-based training for veteran staff on either the foundational communication skills or individual-specific plans and equipment.
- The Facility had formed a Communication Committee. The Committee acknowledged the "reality of communication devices not being utilized in individuals' homes" as a major concern. The Committee agreed to start with the basics by ensuring that equipment/tools were present in the home and in working order. It was positive that the Facility had begun to actively address this issue, because the Monitoring Team's observations continued to identify individuals who did not have their AAC devices with them, or staff were not assisting them to use the devices.

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

- Progress continued to be observed in the area of habilitation services in the development of improved skill acquisition programs (SAPs), including desensitization plans. This included the continued revision of the SAP format, including a revised data collection methodology. Plans reviewed adhered to this revised format, but concerns regarding the adequacy of the SAPs and data collection remained.
- Estimates of engagement continued to reflect less than desirable levels of engagement during brief onsite observations. Revisions in the methods used to estimate engagement as well as integrity of SAP implementation was underway, and appeared to require additional technical support and oversight to ensure their adequate development and implementation.
- Assessments, including Personal Focus Assessments, Functional Skills Assessments, and Vocational Assessments, continued to demonstrate concerns regarding their adequacy.
- Efforts were observed in improving and expanding the resources available to support training of direct support professionals in implementing active treatment, including SAPs. However, the Facility should ensure that these

additional staff members are competent trainers. That is, they should be skilled at conducting competency-based training. The provision of formal skill programming in vocational and community-based settings remained a concern. This included the continued lack of improvement in opportunities for individuals in off-campus vocational settings.

Most Integrated Setting

- 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. More teams were using the standardized list. However some teams still identified individuals' needs as the obstacle to placement as opposed to the lack of supports in the community to meet the individuals' needs. Based on the Monitoring Team's review of action plans to overcome the obstacles identified, few included plans, and problems were noted with their quality and individualization.
- The teams at LBSSLC had begun to implement 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 Not all assessments included this piece. However, team discussions, as documented in a sample of recent ISPs, often reflected disagreements amongst professional members of the team that were not resolved. Even when team members agreed, the discussion reflected a polling of team members as opposed to a consensus. As a result, the professional members of the team did not make one joint recommendation to the individual or the Legally Authorized Representative.
- With regard to the identification of essential and nonessential supports, since the Monitoring Team's last review, no progress had occurred. Since the last review, only three individuals had transitioned from the Facility to the community. Better documentation was available 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. However, follow-up of concerns that were identified was not consistently completed.

Consent

- DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this section of the Settlement Agreement. The Guardianship Policy had been disseminated, and the policy on consent remained in the development phase. The State Office Guardianship/Advocate policy just recently had been issued, and the Facility had not yet operationalized it. As discussed below, this resulted in limited progress being made at the Facility level.
- LBSSLC indicated that no instrument or process was available to determine functional capacity. It was anticipated that the State Office policy on consent would provide guidance with regard to this issue. In the meantime, the Human Rights Officer and Post-Move Monitor met with QDDPs to review the processes currently in place that could assist teams in beginning to better define individuals' decision-making capacity. These included the Rights Assessment, Functional Assessment, and Psychological Assessment processes.
- Since the last review, the Facility had modified the tool used to monitor ISP meetings. An indicator was added to determine if teams were discussing guardianship with families at individuals' annual ISP meetings. This was a positive addition. Based on the Monitoring Team's review of ISPs, although teams often identified that individuals did not have guardians and had difficulty with decision-making, the discussion appeared limited. In the ISPs reviewed, teams made no delineation of an individual's priority need for a surrogate decision-maker, and little planning appeared to occur in relation to alternatives to guardianship or identifying potential guardians.
- The updated prioritized list included names of 92 individuals served by LBSSLC. As described in the last report, teams had met, and with the assistance of the Human Rights Officer and Post-Move Monitor identified individuals' level of priority based on the list of factors delineated in the Settlement Agreement. At the time of the review, Lubbock supported 220 individuals, of whom approximately 42% 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, 42 individuals had a Priority I need for guardianship, 42 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. Since the Monitoring Team's last review, these efforts had been successful in securing guardians for eight individuals, with another two individuals in some phase of the process. These efforts consisted largely of identifying family members, friends, and former staff members to petition the court for guardianship.
- Since the last review, another success that the Facility had was in working with the Family Association to set up a fund to assist with guardianship costs for individuals for whom payment of the associated fees and expenses would potentially prohibit them from obtaining a guardian. Facility staff were in the process of developing an application form, and working with the Family Association to finalize the process that would be utilized to

review and approve applications. The Family Association and the Facility should be commended for this joint effort that should assist greatly in obtaining guardians for individuals who need them.

Recordkeeping and General Plan Implementation

- Since the last review, the Facility had made progress in a number of areas in relation to recordkeeping. For example, a new Medical Records Clerk had begun to reorganize the Master Records, and this time-consuming project was approximately half way completed. To improve the security of records, secure bins had been purchased and placed in open copy rooms. The Unified Records Coordinator had begun providing training on recordkeeping at New Employee Orientation (NEO). With the implementation of the procedure for the submission and filing of documents in the Active Records now completely underway, improvements were noted in the availability of documents in records, and greater accountability had been established. Similarly, the process for checking out the Active Records also appeared to have had a positive impact.
- As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. Some of the issues that staff verbally identified included legibility, gaps in records, and the inclusion of the most current information in the record. To begin to address this on an individual record basis, the Unified Records Coordinator had drafted a process for a Corrective Action Record Deficiencies Tracking Process, dated 3/9/12. It set forth a reasonable process for notifying responsible persons for concerns noted through record audits and following up to ensure corrections were made. The process was schedule for implementation beginning 4/1/12.
- Based on documentation provided, 34 procedures were developed or revised since the previous compliance review. The OPM Committee had reviewed and approved with revisions an additional six. An additional 10 were pending review and approval. In addition, seven Clinical Guidelines has been developed.
- 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.
- 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.
- 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 completeness of the records, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
o Review of Following Documents:
o For Sample #C.1, ten individuals with a total of twenty-four restraints were selected from lists the Director of Behavioral Services provided. Complete restraint records were requested, including Restraint Checklists, Face-to-Face Assessments, Debriefing and Reviews for Crisis Intervention Restraint forms, Positive Behavior Support Plans (PBSP), and Safety Plans for Crisis Intervention (SPCI) and, for each restraint, the documentation of any and all reviews of this restraint information for: Individual #31, Individual #213, Individual #240, and Individual #288, for the following dates and times:
<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th></tr>
<tr><td>Individual #31</td><td>2/17/12</td><td>12:04 p.m.</td></tr>
<tr><td></td><td>2/19/12</td><td>1:46 p.m.</td></tr>
<tr><td></td><td>3/6/12</td><td>2:13 p.m.</td></tr>
<tr><td></td><td>3/6/12</td><td>2:15 p.m.</td></tr>
<tr><td></td><td>3/10/12</td><td>2:57 p.m.</td></tr>
<tr><td>Individual #213</td><td>9/1/11</td><td>9:45 p.m.</td></tr>
<tr><td></td><td>9/16/11</td><td>8:02 a.m.</td></tr>
<tr><td></td><td>9/16/11</td><td>8:04 a.m.</td></tr>
<tr><td></td><td>9/16/11</td><td>8:07 a.m.</td></tr>
<tr><td>Individual #240</td><td>12/23/11</td><td>7:31 p.m.</td></tr>
<tr><td></td><td>12/23/11</td><td>9:11 p.m.</td></tr>
<tr><td></td><td>12/23/11</td><td>9:15 p.m.</td></tr>
<tr><td></td><td>12/23/11</td><td>9:20 p.m.</td></tr>
<tr><td>Individual #288</td><td>11/10/11</td><td>9:13 p.m.</td></tr>
<tr><td></td><td>11/10/11</td><td>9:14 p.m.</td></tr>
<tr><td></td><td>11/22/11</td><td>7:51 p.m.</td></tr>
<tr><td></td><td>11/22/11</td><td>7:53 p.m.</td></tr>
<tr><td></td><td>11/28/11</td><td>8:54 p.m.</td></tr>
</table>
In addition, restraint checklists only were reviewed for single episodes of restraint for:
<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th></tr>
<tr><td>Individual #7</td><td>12/5/11</td><td>9:55 a.m.</td></tr>
<tr><td>Individual #57</td><td>11/28/11</td><td>10:17 p.m.</td></tr>
<tr><td>Individual #131</td><td>3/8/12</td><td>2:41 p.m.</td></tr>
<tr><td>Individual #155</td><td>2/18/12</td><td>2:14 p.m.</td></tr>
<tr><td>Individual #220</td><td>11/22/11</td><td>8:26 p.m.</td></tr>
<tr><td>Individual #221</td><td>12/27/11</td><td>6:45 p.m.</td></tr>
</table>
</td></tr>
</table>

- For Sample #C.2, the following documentation was requested for a sample of 30 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. However, the Facility provided copies of this documentation for 15 staff only. Sample #C.2 consists, therefore, of 15 staff;
- For Sample #C.3, copies of the medical restraint documentation were requested for Individual #45, Individual #95, Individual #174, and Individual #245;
- Sample #C.4 included restraint documentation for the following eight individuals who had experienced chemical restraint:

Individual	Date of Restraint	Time of Restraint
Individual #25	3/1/12	9:42 a.m.
Individual #33	2/17/12	8:15 p.m.
Individual #51	10/2/11	9:05 a.m.
Individual #57	12/30/11	4:10 p.m.
Individual #213	1/30/12	8:31 a.m.
Individual #242	1/24/12	9:34 a.m.
Individual #288	10/2/11	9:10 p.m.
Individual #299	2/29/12	2:00 p.m.

- For Section C.4, Positive Behavior Support Plans, as available for: Individual #6, Individual #116, Individual #237, Individual #156, Individual #57, Individual #165, Individual #230, Individual #124, Individual #94, Individual #31, Individual #190, Individual #240, and Individual #184;
- Sample for Section C.6, Restraint Checklists, Face-to-Face Debriefing Reports and Safety Plan for Crisis Intervention as provided, for: Individual #240 and Individual #288;
- Sample for Section C.7, including Restraint Checklists, Face-to-Face Debriefing Reports, Safety Plan for Crisis Intervention, Positive Behavior Support Plan, Individual Support Plans (ISP), ISP Addendums, Monthly Behavioral Services Reviews, as provided, for: Individual #31, Individual #240, and Individual #288
- Presentation Book for Section C;
- LBSSLC Policy: Health Services, Dental/Medical Sedation and Restraint, dated 10/17/11;
- LBSSLC Policy: Positive Behavior Support, Limitation of Restraint as a Crisis Intervention, dated 11/25/09;
- Incident Management Review Team (IMRT) Meeting Minutes, from the first Monday of each week since the last site visit;
- List of individuals (5) with Safety Plans;
- Restraint Report for LBSSLC from 10/1/11 to 2/10/12;
- Most recent "Do Not Restrain" list with the names of 134 individuals;
- Consultation report for Individual #239;
- Completed Monitoring Tools for Section C;

	○ Plan of Improvement/Self-Assessment for Section C, dated 2/29/12; ○ Minutes of the Human Rights Committee, dated 10/12/11 to 2/8/12; ○ Minutes of the Quality Assurance/Quality Improvement Committee, dated 10/4/11 to 3/8/12; and ○ List of injuries (77) that occurred to individuals and to staff during the use of restraints from 4/2/11 to 12/23/11. ○ **Interviews with**: ○ Libby Allen, Facility Director; ○ Jim Forbes, M.Ed, BCBA, Director of Behavioral Services, and Carolyn Milton, BCBA; ○ Melinda Voight, Risk Manager; ○ Dawn Ripley, Director of Quality Assurance; ○ Rodney McWilliams, Incident Management Coordinator; ○ Don Minnis, RN, BSN, Chief Nurse Executive (CNE); ○ Jeremy Ellis, RN, Quality Enhancement (QE) Nurse; ○ Eddie McFadden, RN, Quality Enhancement Nurse; and ○ Informal interviews/conversations with staff and individuals, including observation of Individual #33, Individual #60, Individual #31, Individual #264, and conversation with Individual #94. ○ **Observations of**: ○ Incident Management Review Team meetings, on 3/19/12, 3/20/12, and 3/21/12; ○ Executive Safety Committee meeting, on 3/21/12; ○ Quality Assurance/Quality Improvement Committee meeting, on 3/21/12; ○ Human Rights Committee meeting, on 3/20/12; and ○ 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: According to LBSSLC's Self-Assessment, dated 2/29/12, the Facility found substantial compliance with Section C.2, regarding the prompt termination of restraint and with Section C.3, regarding the development and implementation of policies governing the use of restraint. The Facility made an assessment of noncompliance with the remaining provisions. The Monitoring Team assessment was consistent with the Facility's assessment that it was in compliance with Section C.2, as well as with Section C.3. The Director of Behavioral Services had designed and implemented a number of activities to evaluate both the processes and outcomes essential to compliance with the provisions of Section C. For example, random sampling was utilized to review documentation related to restraint use, staff training records were examined to determine whether the necessary knowledge competencies had been attained, and data related to the restraint use of certain individuals was analyzed and discussed with the responsible clinical professionals. Significantly, each recommendation from the Monitoring Team was scrutinized in order to

	develop appropriate corrective actions, and an in-depth assessment was conducted of any "improper restraints" to determine whether the necessary remedial actions were taken per Facility policies. Each of these activities contributed to the reduction of unnecessary restraint and the Facility's progress towards compliance with the provisions of the Settlement Agreement. The Facility's efforts, while effective, could be expanded by increased direct observation in the residential and programmatic environments. A deeper sense of the environmental and other constraints would contribute to the implementation of relevant self-assessment strategies. Additionally, it would be instructive if the Director of Behavioral Services were approved to view the videotapes of restraint in order to evaluate whether less intrusive measures were implemented first.
	Summary of Monitor's Assessment: As stated in previous reports, there was clear evidence that LBSSLC had worked diligently to monitor and evaluate the use of restraint, and to design and implement alternative interventions. During the Monitoring Team's onsite visit, it was again noted that the use of restraint had been effectively replaced for some individuals by more individualized and less restrictive approaches in the residential and programmatic areas of the Facility. At the same time, however, numerous opportunities were observed where the Facility failed to ensure that individuals' Positive Behavior Support Plans adequately addressed their needs and that they were implemented consistently. Teams did not consistently address individuals' environmental, adaptive skills, and biological, medical, psychosocial issues that potentially led to restraint. For example, in their Personal Focus Assessments and Individual Support Plan meetings, individuals with complex and challenging behaviors expressed a clear preference for integrated settings, such as supported competitive employment, community social events, and typical local sites with options for shopping, entertainment, and social interaction with peers. These preferences were noted, but not offered in a consistent and predictable manner. Opportunities were missed to utilize community-based resources and meaningful interactions with people without a disability. During the site visit, it was evident that the Facility continued to devote serious attention to achieving compliance with the obligations of Section C. In part, this commitment was demonstrated by the disciplinary and other corrective actions taken when the improper use of restraint was confirmed. Although compliance had not yet been achieved with the majority of the provisions in Section C, the Facility, through its self-assessment activities and other initiatives had outlined a reasonable and conscientious set of actions to continue its progress towards that goal. The Facility leadership and staff were to be commended for their vigorous efforts to ensure that training requirements were fully met. At the time of the site visit, all employees who were required to be trained in the appropriate use of restraint had met this expectation. Furthermore, the review of incident investigations confirmed that improper restraint would not be tolerated. Disciplinary action (dismissal) was taken against employees who used prone restraint and who failed to comply with the mandates of the Do Not Restrain List. This single brief episode of improper restraint resulted in additional staff training, and in an enhanced effort to alert staff to individuals who cannot be restrained because of medical or psychological reasons.

	Despite the continued efforts and progress described above, 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. Since the last site visit, the Chief Nurse Executive and the Director of Behavioral Services attempted to remediate this problem by redesigning the protocol for notification of nursing personnel. The effect of this new method of alerting nurses to the need to respond promptly to an episode of restraint will be evaluated during the next site visit. In summary, although areas of noncompliance were evident based on the Monitoring Team's review, the efforts to reduce the use of restraints by the Facility Director, the Director of Behavioral Services, the Psychologists assigned to the residential units, the Unit Directors, and the direct support professionals were noted and commended. LBSSLC demonstrated considerable expertise in the design of individualized approaches to replace the intrusiveness and restrictiveness of physical and chemical restraint. These efforts were implemented in a large facility setting with serious constraints in the environment, the combination of individuals with distinct needs for support, and the limited availability of more integrated settings with shared expectations and natural consequences for behavior. If such alternatives to restraint are to be sustained and expanded, individuals' treatment plans should take into account the many environmental, adaptive skills, and biological, medical, psychosocial issues that potentially lead to restraint. As appropriate, this should include more frequent opportunities for age-appropriate and integrated experiences, such as supported competitive employment and social interaction with peers, particularly for those who clearly express that choice.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only	Based on information the Director of Behavioral Services provided in the Restraint Report, between 10/1/11 and 2/10/12: ▪ There was no authorized use of mechanical restraint. However, one individual was restrained improperly in her recliner when a seatbelt was used without authorization. This incident was investigated by DFPS and abuse was confirmed; ▪ A total of 37 individuals experienced a form of restraint; ▪ Nineteen of these individuals had medical restraint use only; ▪ One individual experienced more than 20 restraints during this timeframe. Individual #288 was restrained 24 times. ▪ There were three chemical restraints used for the above individual. Using this same set of information, within the above timeframe, the Facility documented: ▪ 38 crisis intervention* restraints; ▪ 39 emergency personal restraints; and ▪ 11 chemical restraints during a behavioral crisis. *These were identified in Facility documentation as programmatic restraints. However, policy prohibited programmatic restraints. The terminology remained in the data system to describe restraints used in accordance with the individual's Safety Plan.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>restraint techniques approved in the Facilities' policies shall be used.</td><td>Since the Monitoring Team's last report, according to data the Facility provided, the use of restraints had been reduced. Unfortunately, the Monitoring Team did not have complete data to provide information for equal six-month periods. However, the following information was provided:

<table>
<tr><th>Type of restraint</th><th>3/1/11 to 8/31/11</th><th>10/1/11 to 2/10/12</th></tr>
<tr><td>Crisis intervention</td><td>175</td><td>38</td></tr>
<tr><td>Emergency personal</td><td>53</td><td>39</td></tr>
</table>

In the Restraint Report dated 10/1/11 to 2/10/12, there were a total of 77 restraint episodes documented. The majority of restraints were documented for Individual #288 (24), Individual#124 (nine), Individual #240 (seven), and Individual #57 (six). The data for 9/11, as documented in the report on restraint trends provided by the Director of Behavioral Services, was available only in bar graph form. As a result, the exact number of restraints, apparently below twenty, could not be entered into the chart above. The bar did does show a downward trend from 7/11 to 10/11.

As described above, a sample, referred to as Sample #C.1, was selected. The individuals in Sample #C.1 included: Individual #7, Individual #31, Individual #57, Individual #131, Individual #155, Individual #213, Individual #220, Individual #221, Individual #240, and Individual #288. The specific restraint episodes are listed above in the documents reviewed section. The twenty-four restraint episodes reviewed for this report represented 31% of restraints documented over the last six months, based on the reports the Facility provided.

<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 evidence to indicate that during the last six months, prone restraint was used without authorization at LBSSLC for one individual. While attempting to ensure that Individual #213 did not further injure his fractured leg, staff utilized a restraint hold that resulted in a prone position. Upon entering the room, the Restraint Monitor immediately terminated the restraint. Although the impermissible restraint was brief (reportedly six seconds), the Facility adhered to its policy that prone restraint was not permitted. Two employees were dismissed and a third employee was disciplined for failing to seek timely assistance.

If staff were unable to hold an individual in the proper position during a restraint episode, they were instructed to release the restraint hold. During the review, adherence</td><td></td></tr>
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		to this directive was noted in 24 restraint checklists for ten individuals. With one exception, this provision of the Settlement Agreement related to prone restraint appeared to be met. In this instance, the safeguards in place (i.e., the Restraint Monitor) were effective in terminating the improper restraint as soon as possible. In addition, the Facility appeared to take appropriate follow-up corrective action. Based on informal interviews with 18 direct support and clinical professionals, all had been trained regarding the prohibition on 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 restraint records were reviewed for Sample #C.1, for the period from 9/1/11 to 2/10/12, which included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ In 18 out of 24 records (75%), there was documentation showing that the individual posed an immediate and serious threat to self or to others. However, the documentation varied considerably in the level of detail and specificity. Therefore, it was difficult to determine the true degree of risk to the individual or to others in the vicinity. For example, the documentation for the restraint episode on 3/6/12 for Individual #31 stated: " Reason for agitation is unknown. Spoke to 6/2 (shift), they stated they did not know reason for aggression, used shoe as a weapon, attempted to strike staff." In this instance, the distance between the individual and the staff was not documented; the individual's demeanor was not described; and the actual gesture was not specified. ▪ For the 24 restraint episodes (100%) reviewed, there was no specific evidence that restraint was used as a punishment or for the convenience of staff. However, the lack of consistently detailed information in the restraint checklist about the rationale for restraint and the alternative interventions attempted continued to be of concern in evaluating this requirement. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment, and only after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner. To assess these requirements, a sample of four individuals' records were reviewed, including restraint checklists, PBSPs, and SPCIs, as available, for Individual #288, Individual #240, Individual 213, and Individual #31:	

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		▪ Of the four individuals reviewed, one (25%) of the records indicated that restraint was not used in the absence of or as an alternative to treatment, and only after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner. That is, information provided on the Restraint Checklist suggested that interventions prescribed within the PBSP were attempted prior to restraint. An example in which adequate treatment was present and less restrictive options were attempted included: o The restraint record, dated 2/17/12, 12:04 p.m., for Individual #31 indicated that staff attempted multiple interventions to avoid restraint in response to aggression toward staff and peers. According to recorded checkmarks on the Restraint Checklist, this included "prompted coping skills," "interventions in PBSP," "verbal prompt," "redirection," "changed environment," and "moved other(s) away." Written descriptions on the checklist indicated that staff redirected him to his room, where they modeled and encouraged the use of deep breathing. The use of many of these interventions (verbal redirection, change in environment) was consistent with the PBSP that was in place, dated 1/26/12. However, at that time, the PBSP was a brand new plan and did not include identification of replacement behaviors or descriptions of specific coping skills. Consequently, it appeared that the staff attempted to use typical copings skills with Individual #31, even though they were not prescribed in the plan. Although not technically consistent with the PBSP, this showed an effort to intervene by prompting more adaptive responses in an attempt to avoid aggression and, ultimately, restraint. Examples in which inadequate treatment was present and it was not clear if less restrictive options were appropriately attempted included: o The restraint record, dated 12/23/11, 7:31 p.m., for Individual #240 indicated that staff attempted multiple interventions in response to aggressive behavior. According to recorded checkmarks on the Restraint Checklist, this included "prompted coping skills," "interventions in PBSP and Safety Plan," "verbal prompt," "redirection," "PMAB protection skills," and "removed dangerous weapon." Written descriptions on the checklist under the heading: "If PBSP, Replacement Behavior prompted," included "prompted coping skills." It was unclear from this description which skills were being prompted. More specifically, there were no clearly identified or conspicuously described coping skills (e.g., deep breathing, counting, etc.) in the PBSP that was in place at the time, dated 8/2/11. The replacement behavior identified in that PBSP identified "problem solving" but, according to the plan, these replacement responses were only to be encouraged once the Individual	

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		has calmed. It appeared that staff had not properly implemented the PBSP, because they prompted "coping skills," when they should not have. o Written descriptions on the restraint record for Individual #213, dated 9/1/11, 9:45 a.m., indicated that staff prompted the use of his replacement behavior cards and breathing techniques following aggression and property destruction. No other information regarding other interventions was provided. It appeared that other interventions as prescribed in the PBSP, dated 11/3/11, should have been implemented, including telling him to "stop" and/or prompting him to a quieter area. From the limited recorded responses, it is unknown if these were tried. In addition, the plan did encourage the use of deep breathing and counting as coping skills, which appeared to have been prompted. However, the use of the replacement behaviors (i.e., replacement cards) was prescribed for use only after the incident was over. Descriptions provided indicated that replacement cards were prompted during the incident. o The restraint record, dated 11/10/11, 9:13 p.m., for Individual #288 indicated that staff attempted multiple interventions to avoid restraint (basket hold) in response to aggression toward staff. According to recorded checkmarks on the Restraint Checklist, this included "prompted coping skills," "interventions in PBSP," "interventions in Safety Plan," "verbal prompt," "redirection," "PMAB protection skills," "removed dangerous object," "changed environment," "moved other(s) away," and "moved furniture." However, staff did not note descriptive information regarding other specific interventions attempted to avoid restraint, specifically regarding the prompting of replacement behaviors. That is, no written descriptions were provided regarding the specific incident and his response to attempted interventions. Consequently, it was unclear if the replacement behavior ("tolerance training") was attempted or appropriate given the crisis situation. Indeed, additional information might have been helpful (e.g., to the restraint reduction committee) in determining if the identified replacement behavior(s) in the PBSP (dated 11/3/11) were functionally equivalent replacements of aggression and property destruction. As noted above, additional descriptive information would have been helpful when reviewing these incidents and determining the effectiveness of current interventions, as well as in planning future strategy development. This current finding was consistent with restraint record review the Facility completed and reported in the Self-Assessment, dated 2/16/12. More specifically, the self-assessment reported that the specific	

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		antecedents that led to restraint were not sufficiently documented in 33% of records reviewed. In addition, the Facility found that the specific interventions that were attempted to avoid restraint were not described in sufficient detail in 92% of records reviewed. Documentation provided demonstrated substantial efforts to train direct support professionals, professional and administrative staff to adequately complete restraint documentation, including providing descriptive information on what triggered the dangerous behavior as well as the specific interventions attempted to avoid restraint, including the use of replacement behaviors. These trainings occurred in late January and February 2012. The two restraint checklists with no written description or minimal information (i.e., dated 11/10/11 and 12/23/12 for Individual #288 and Individual #240, respectively) were completed prior to this training. The one restraint checklist with the most helpful information was completed after this training (i.e., dated 2/17/12 for Individual #31). The Monitoring Team's next review will examine if this improving trend continues. One area of additional concern was noted regarding the adequate completion of restraint reports. That is, the restraint report form had been revised in the past to identify the dates on which direct support professionals involved in the restraint were trained on the PBSP and SPCI, when appropriate, of the individual restrained. Review of the restraint reports listed above evidenced that this information was missing for 100% of the direct support professional involved in the related restraints. LBSSLC policies identified a list of approved restraints. Based on the review of 24 restraint episodes, 24 (100%) were approved restraints. There was evidence that restraints were terminated in 15 out of 24 episodes (63%), if the proper position could not be maintained, or if the individual escaped from the hold. 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 as well. 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 the Interdisciplinary Teams were just beginning to reference this as a possibility. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment, and only after a graduated range of less restrictive measures has	

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		been exhausted or considered in a clinically justifiable manner. As noted above, staff did not, in most cases, adequately implement strategies prescribed within Behavior Support Plans to potentially prevent the need for restraint. In addition, the Monitoring Team continued to note problems with regard to the documentation related to whether or not individual posed a serious an immediate threat. Consequently, the Facility remained out of compliance with this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Five individuals at LBSSLC had Safety Plans. Three of the ten individuals included in Sample #C.1 (i.e., Individual #221, Individual #240, and Individual #288) had Safety Plans that were reviewed and approved by the Human Rights Committee. Each of their Safety Plans defined the use of restraint, including appropriate criteria for release. ▪ In 15 out of 24 episodes, restraint ended when the staff member was unable to sustain the restraint hold or the individual escaped; ▪ For the three individuals who had adequate Safety Plans, five restraint records 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, lasting from less than a minute to eight minutes. In four restraint records, sufficient documentation was included to show that the individual was released when no longer a danger to self or others. The Facility was determined to be in substantial compliance with this provision. This was consistent with the finding in the Monitoring Team's last 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	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. On 1/2/12, additional training for direct support professionals had begun, and was to be completed by 6/29/12. Training focused on the critical considerations at decision points before, during, and after restraint. Instruction on the expansion of the documentation of antecedents and the interventions attempted to avoid restraint also was included in the training curriculum. The Director of Behavioral Services acknowledged that the restraint checklist documentation regarding the rationale for restraint use needed to include more detail. Additionally, the Monitoring Team recommended that the incident involving the prone restraint of Individual #213 suggested the need for training scenarios that were focused on addressing more challenging situations.	Substantial Compliance

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	competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Since the Monitoring Team's last onsite visit, the following guidelines had been issued: How to Respond to Crisis Intervention Restraint Danger Points, Self-Monitoring Tool for ISPA of more than Three Restraints in a 30-Day Period, Crisis Intervention Restraint Contacts flow sheet, and Guidelines for Case Referral to Behavior Support Committee (BSC). The incident involving the improper restraint of Individual #213 prompted the design and implementation of staff training on the Do Not Restrain List. In particular, the orientation sheet for pulled staff was revised to include further instruction on this directive. The Medical Provider Compliance Nurse was assigned responsibility for keeping the Do Not Restrain List current. Documentation the Facility submitted for 11/11, 12/11 and 1/12 showed 99% to 100% compliance with PMAB training requirements. This finding compared favorably with the results for 4/11 through 8/11, as previously reported. For Sample #C.2, the Monitoring Team requested the following documentation for a sample of 30 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. However, Facility provided copies of this documentation for 15 staff only. Sample #C.2 consists, therefore, of 15 staff. Of these, documentation indicated that training requirements were current and complete for 100% of the sample. Based on discussions with 18 direct support and clinical professionals, all were able to describe their training regarding the use of restraint, and all reported they were current with their training requirements. Based on interviews and documentation provided during the site visit, the Facility was determined again to be in compliance with this provision of the Settlement Agreement.	
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	Based on a review of the restraint episodes in Sample #C.1, sufficient evidence was found that restraint was used as a crisis intervention in 18 out of 24 (75%) of the episodes. For example, there was a lack of clearly detailed information on the restraint episode involving Individual #221 on 12/27/11, and for three of the four restraint episodes on12/23/11 at 9:11 p.m., 9:15 p.m. and 9:20 p.m. involving Individual #240. Of the thirteen PBSPs reviewed (as listed above in the documents reviewed section), 13 (100%) showed no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, as presented earlier and reported in the Monitoring Team's previous reports, the Facility policy did not allow for the use of restraint for reasons	Noncompliance

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	individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	other than crisis intervention. In 24 of 24 (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 #213, who was on the "Do Not Restrain" list, had one unauthorized restraint episode. DFPS investigated this episode, and a finding of abuse was substantiated. As a result, three staff received disciplinary action, including termination from employment. This incident led to the revision of protocols regarding the Do Not Restrain List, including the orientation required for pulled staff. 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 134 individuals were on the "Do Not Restrain" list, representing 61% of the 221 individuals living at LBSSLC. As noted during the Monitoring Team's previous visits, a Dental Desensitization policy as well as a Desensitization Committee had been initiated, and initial Dental Desensitization plans had begun to be developed. As noted in the Monitoring Team's most recent report, 12 plans had been written and targeted: 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. At that time, although the plans appeared to be an improvement over previously reviewed desensitization plans, it was recommended that the plans be more individualized, as well as include all the necessary elements for effective skill acquisition training. Currently, dental desensitization plans were now adhering to the revised skill acquisition program (SAP) format. That is, Psychologists had begun writing dental desensitization programs using the same format used to write typical SAPs. To assist in the adequate development of these SAPs, a self-monitoring checklist was developed, dated 12/9/11, for Psychologists to follow when writing these plans to help ensure that all the required elements were included. The checklist appeared very comprehensive, and seemed to include all of the necessary elements of effective skill acquisition programs. Documentation provided evidenced several trainings conducted with Psychologists on this new self-monitoring checklist, and examples of completed checklists were provided as well. As described in Section S.1, the current review of a sample of desensitization plans found the plans to be inadequate. That is, one or more critical elements within the reviewed plans appeared to be either missing or inadequate. Specific feedback regarding the quality of reviewed dental desensitization SAPs are discussed with regard to Section S.1.	

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		In addition to efforts to improve the actual SAPs, the Facility appeared to be thoughtfully examining the larger process of identifying individuals who required support related to dental care, as well as determining the nature of that support. That is, the desensitization committee developed a "desensitization priority list" of individuals who were identified as needing a formal desensitization SAP. Once identified, the individual's interdisciplinary team was expected to discuss the nature of the need, as well as discuss the findings of the dental desensitization assessment form completed by the dental staff. This form was developed to identify the skill level of an individual in completing responses related to dental care. The Psychologist then utilized this information to develop a targeted and individualized SAP. According to verbal reports of the Director of Behavioral Services, approximately 32 (29%) dental desensitization plans had been completed out of 110 that had been identified as needed. Similarly, only eight (33%) medical desensitization plans have been completed out of the 24 that have been identified as needed. Overall, efforts to improve dental desensitization plans were noted. The quality and individualization of desensitization plans will need to continue to improve in order for the Facility to be in substantial compliance with this section of the Settlement Agreement. As also documented in the last report from the Monitoring Team, the use of restraint once again on an individual on the "Do Not Restrain" list was very troubling. As a result, the Facility remained in noncompliance 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 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	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. Additional training was designed and implemented for restraint monitors. A list of 21 trained restraint monitors was included in the documentation received from the Facility. Since the Monitoring Team's last onsite visit, three additional restraint monitors had been added and trained. Based on a review of 24 restraint records (Sample #C.1.), a face-to-face assessment was conducted: ▪ In 22 out of 24 incidents of restraint (92%) by an adequately trained staff member. There were no restraint debriefing forms provided for the off-site restraint of Individual #221 on 12/27/11 at 6:45 p.m. The debriefing form for the restraint of Individual #240 on 12/23/11 at 7:31 p.m. was included with restraints that occurred nearly two hours later; ▪ In 21 out of 24 instances (88%), the assessment began as soon as possible, but	Noncompliance

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	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.	no later than 15 minutes from the start of the restraint. The Restraint Monitor arrived 20 minutes after the restraint was initiated for Individual #57 on 11/28/11 at 10:17 p.m., and for Individual # 7 on 12/5/11 at 9:55 a.m. There was no documentation regarding the monitoring of Individual #240 on 12/23/11 at 7:31 p.m. until nearly two hours later; ▪ In 22 out of 24 instances (92%), the documentation showed that an assessment was completed of the application of the restraint. There was no documentation of an assessment of Individual #221 on 12/27/11 at 6:45 p.m. or for Individual #240 on 12/23/11 at 7:31 p.m.; and ▪ In 22 out of 24 instances (92%), the documentation showed that an assessment was completed of the circumstances of the restraint. As stated above, this information was not provided for the restraints of Individual # 221 on 12/27/11 and Individual # 240 on 12/23/11 at 7:31 p.m. Based on a review of 24 restraint records for 10 individuals for restraints that occurred at the Facility (i.e., Individual #213, Individual #288, Individual #31, Individual #240, Individual #131, Individual #221, Individual #57, Individual #7, Individual #220, and Individual #155), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 14 (58%) of the instances of restraint. Records that did not contain documentation of this included: Individual #213 on 9/16/11 at 8:02 a.m., 8:04 a.m., and 8:07 a.m.; Individual #288 on 11/22/11 at 7:51 p.m., 7:53 p.m., and on 11/28/11; Individual #240 on 12/23/11 at 7:31 p.m.; Individual #221 on 12/27/11; Individual #57 on 11/28/11; and Individual #7 on 12/5/11. ▪ Monitored and documented vital signs in 19 (79%) episodes. Records that did not contain documentation of this included: Individual #213 on 9/16/11 at 8:04 a.m., and 8:07 a.m.; Individual #288 on 11/10/11 at 9:13p.m; Individual #221 on 12/27/11; and Individual #7 on 12/5/11. Problematic issues noted that resulted in noncompliance included the vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. In addition, noncompliance with this indicator was found for individuals whose Restraint Checklists indicated that individuals had significantly high or low values for their vital signs, but did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ The indicator regarding "monitored and documented vital signs for two hours from the initiation of the restraint" was not assessed, because the State Restraint policy that included this requirement was still in draft form and, thus, had not been implemented at the time of the review. ▪ Monitored and documented mental status in two (8%) episodes. Records that did not contain documentation of this included: Individual #213 on 9/1/11, and	

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		9/16/11 at 8:02 a.m., 8:04 a.m., and 8:07 a.m.; Individual #288 on 11/10/11 at 9:13 p.m., and 9:14 p.m., 11/22/11 at 7:51 p.m., and 11/28/11; Individual #31 on 2/17/12, 2/19/12, and 3/6/12 at 2:13 p.m., and 2:15 p.m., and 3/10/12; Individual #240 on 12/23/11 at 7:31 p.m., 9:11 p.m., 9:15 p.m., and 9:20 p.m.; Individual #131 on 3/8/12; Individual #221 on 12/27/11; Individual #57 on 11/28/11; Individual #7 on 12/5/11; and Individual #155 on 2/18/12. Problematic issues noted that resulted in noncompliance included either the mental status was not recorded, was generic (e.g., "alert, calm, oriented, and aggressive") without a specific description supporting the status included, or the mental status section was marked as refused. As noted in the previous reports, to obtain a mental status, the individual's cooperation is not required. The documentation of the mental status should include a description of the individual's behaviors indicating the mental 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 as being agitated, and does not warrant any type of cooperation to obtain. From discussions with the Chief Nurse Executive and the QE Nurses, the Nursing Department had not been conducting audits addressing the nursing documentation regarding restraints. Although a QA Program Compliance Monitor (PCM), who was not a nurse, had been conducting audits of the nursing documentation for restraints, the Facility's data only addressed the completion of the required nurse documentation, and not the quality of the nursing documentation according to Nursing Standards of Practice. Thus, the Facility's data did not accurately reflect the significant problematic issues that were found above, or the issues the Monitoring Team identified with regard to Section C.6 that addresses a licensed health care professional's documentation of assessment for any restraint-related injuries or other negative health effects. However, from discussions with the QA Nurse, a nurse would audit this area by the time of the Monitoring Team's next review. There were two off-campus restraint episodes. On 10/20/11, Individual #124 was restrained off-campus, but a nurse did not examine him upon his return to LBSSLC. On 12/27/11, Individual #221 was restrained off-campus. The restraint was not documented, and a nurse did not examine him within 30 minutes of his return, as required. A letter of warning was issued to the employee who failed to complete the debriefing form. Sample #C.3 was selected from the list of 19 individuals who had medical restraint in the last six months. Documentation was provided for the four Individuals in the sample. ▪ In zero out of four (0%), the physician specified the schedule of monitoring required;	

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		▪ In zero out of four (0%), the physician specified the type of monitoring required; ▪ In zero out of four of the medical restraints (0%), appropriate monitoring was completed either as required by the Settlement Agreement or as the physician prescribed. The RN/LVN Evaluation outlined on the second page of the restraint checklist was not completed for any of the four individuals.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In 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.	A sample (Sample #C.1.) of 24 restraint checklists for individuals in restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In 100%, continuous one-to-one supervision was provided; ▪ In 100%, the date and time restraint was begun was documented; ▪ In 100%, the location of the restraint was documented; ▪ In 75%, information about what happened before the restraint, including the change in behavior that led to the restraint, was included. The quality of this description was not consistent. There were cursory, repetitive notes, especially when multiple episodes occurred in a short time. ▪ In 21%, 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 detailed; ▪ In 75%, the specific reasons for the use of the restraint were stated; ▪ In 96%, the method and type (e.g., medical, dental, crisis intervention) of restraint was identified. This information was lacking for the restraint of Individual #213 on 9/16/11 at 8:07 a.m.; ▪ In 100%, the names of staff involved in the restraint episode were listed, but training dates and signatures were not always provided. As noted above, the restraint checklists were reformatted and information about training was excluded; ▪ 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. ▪ In 100%, the level of supervision provided during the restraint episode was described. The level of supervision in all instances was one-to-one; and ▪ In 100%, the date and time the individual was released from restraint was documented.	Noncompliance

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		The Director of Behavioral Services and other key staff at LBSSLC had prioritized the accurate and timely completion of the restraint checklists, as evidenced by the findings above. The quality of the descriptive information requires improvement. Actions were underway to address this recurring deficiency. Based on a review of 24 restraint records for 10 individuals for restraints that occurred at the Facility (i.e., Individual #213, Individual #288, Individual #31, Individual #240, Individual #131, Individual #221, Individual #57, Individual #7, Individual #220, and Individual #155): ▪ In seven (29%), the results were documented of an adequate 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 #213 on 9/1/11, and 9/16/11 at 8:02 a.m., 8:04 a.m., and 8:07 a.m.; Individual #288 on 11/10/11 at 9:13 p.m., and 11/22/11 at 7:51 p.m., and 7:53 p.m.; Individual #31 on 2/19/12, and 3/10/12; Individual #240 on 12/23/11 at 9:11 p.m., 9:15 p.m., and 9:20 p.m.; Individual #131 on 3/8/12; Individual #221 on 12/27/11; Individual #7 on 12/5/11; Individual #220 on 11/22/11; and Individual #155 on 2/18/12. Problematic issues that resulted in noncompliance included either the Post Restraint Assessment section being left blank and/or lacking an appropriate description of injuries, such as the specific size, and location of bruises or scratches. In a sample of 24 records (Sample #C.1), restraint debriefing forms had been completed for 22 out of 24 (92 %) of the episodes reviewed. A sample of four individuals subject to medical restraint was reviewed (Sample #C.3), and in none (0%), there was evidence that the monitoring had been completed as required by the Settlement Agreement or physician's order. There were 11 episodes of chemical restraint documented from 10/1/11 to 2/10/12. In the review of Sample #C.4, it was documented that a debriefing form was completed for six of the eight (75%) individuals in the sample. A psychologist was contacted prior to the administration of chemical restraint in six of eight (75%) instances. The contacts for Individual # 57 and Individual # 242 could not be determined from the information available. In the incidents where the psychologist was contacted, there was adequate documentation that the conditions for the administration of chemical restraint were met, and that less intrusive interventions were not available in only one of the six incidents (17%). This documentation was not present for the chemical restraint of Individual #25 on 3/1/12 at 9:42 a.m.; Individual #33 on 2/17/12 at 8:15 p.m.; Individual #51 on 10/2/11 at 9:05 a.m.; Individual #288 on 10/2/11 at 9:10 p.m., or Individual #299 on 2/29/12 at 2:00 p.m.	

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C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation, dated 3/16/12 (i.e., "LbSSLC Crisis Intervention and Medical/Dental Restraints from September 1, 2012 through March 7, 2012), seven individuals were placed in restraint more than three times in any rolling thirty-day period. Of these individuals, a sample of three individuals (reflecting a sample of 43%) was selected for review to determine if the requirements of the Settlement Agreement were met. This sample included Individual #31, Individual #240, and Individual #288. Restraint Checklists, and Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms, as well as requested documentation, including the ISP, ISP addendums, psychological assessment, SFBA, PBSP, and SPCI, as available, were reviewed for each individual. It should be noted that the PBSP and SPCI in place at the time of the restraints were requested and subsequently reviewed. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. As described above, data on all of the restraints between 9/1/11 and 3/7/12 was provided. Of the total number of restraints reported, a range of dates that met the criterion of "more than three restraints in any rolling thirty day period" were randomly selected for each of the three individuals sampled. These dates are listed below: ▪ Individual #31: 2/17/12 (12:04 p.m.), 2/19/12 (1:46 p.m.), 3/6/12 (2:13 p.m.), and, 3/6/12 (2:15 p.m.); ▪ Individual #240: 12/23/11 (7:31 p.m.), 12/23/11 (9:11 p.m.), 12/23/11 (9:15 p.m.), and 12/23/11 (9:20 p.m.); ▪ Individual #288: 11/10/11 (9:13 p.m.), 11/10/11 (9:14 p.m.), 11/22/11 (7:51 p.m.), and, 11/22/11 (7:53 p.m.). According to verbal reports and documentation provided, efforts to ensure adequate review of restraints that met the more than three restraints in a rolling 30-day period had continued since the last review. This included minor revisions of the ISPA template utilized to review and document the IDT's discussion and recommendations following more than three restraints in any 30-day period. In addition, the "Self-Monitoring Tool for ISPA of more than three Restraints in a 30 day Period" checklist was developed to ensure that the ISPAs contained all of the necessary information. The Director of Behavioral Services provided training on this new self-monitoring checklist as well as the revised ISPA shell to the QDDP Educator (on 12/22/11), QDDPs (on 1/20/12), and	Noncompliance

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		behavioral services staff (on 2/14/12). In addition, documentation reflected continued oversight of ISPAs (i.e., those held in response to more than three restraints in a 30-day period) by the Incident Management Review Team (IMRT). Currently, as described below, although these additional supports were developed and implemented, their adequate and consistent use was not yet evident. Of the three individuals sampled, one of the individuals' teams (33%) met to discuss the more than three restraints in 30 days. The following is the instance in which a team met: ▪ Documentation evidenced that the IDT for Individual #240 met (i.e., ISP Addendum dated 12/27/11) to discuss the four restraints that occurred on 12/23/11. The IDT utilized the revised format designed to facilitate the review of more than three restraints in a 30-day rolling period. The following are examples where teams failed to do this: ▪ The IST for Individual #31 did not appear to meet in response to the four restraints reported between 2/17/12 and 3/6/12. According to provided documentation, the IST met on the following occasions: 1) on 1/27/12, for his ISP meeting; 2) on 2/17/12, to discuss reduction in LOS from enhanced to routine; and 3) on 3/9/12, to discuss his referral to another residence. On 3/9/12, the IDT discussed his aggression toward staff and peers and offered potential supports and recommendations. However, the ISPA template developed specifically following more than three restraints in any 30-day period was not documented (or, if it was, it was not provided). Consequently, a review of the restraints did not appear to have taken place as required. ▪ Documentation (i.e., ISP Addendum dated 12/30/11) reported that the IDT for Individual #288 met to review approximately 19 restraints that occurred between 9/16/11 and 12/5/11. The discussion record on the ISPA indicated that this substantial number of restraints was being reviewed at that time due to "staff's error." The Monitoring Team assumed that "staff's error" reflected the IDT's oversight to hold the required ISPA meetings following more than three restraints in any 30-day period. That is, it seemed that this criteria was met a number of times over the three-month period. Another potential "error" was revealed with the review of other documentation (i.e., "LbSSLC Crisis Intervention and Medical/Dental Restraints from September 1, 2012 through March 7, 2012) that indicated that 24 restraints (including two chemical restraints), not 19 as described in the ISPA, occurred between 9/16/11 and 12/5/11. Consequently, it appeared that in addition to not holding requisite ISPA review meetings as expected, when the meeting was held, a number of restraints were overlooked. In summary, documentation was not available to show that the team had met to review the more than three restraints in a 30-day period.	

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		The above finding (i.e., only 33% of the individuals' teams met to discuss the more than three restraints in a 30-day period) was similar to the Facility's own assessment of adherence to this requirement. More specifically, data reported in the Self-Assessment, dated 2/16/12 indicated that one of five (20%) of individuals sampled had an ISPA review addressing more than three restraints in any 30-day period. Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided, the IDT for Individual #31 did not appear to meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, no evidence was provided that the IDT adequately reviewed potential adaptive skills. ▪ Documentation provided for Individual #240 (i.e., ISP Addendum dated 12/27/11) evidenced that the IDT generally discussed his daily living, communication, and social skills. However, they did not actively and specifically discuss how these skills (or the lack thereof) might be related to the challenging behavior that led to the current restraints. In addition, there was no evidence that the IDT discussed replacement behaviors that could be identified and taught as an alternative to the behavior (aggression) that led to restraint. ▪ Technically, the team for Individual #288 did not meet in a timely manner to review the more than three restraints in 30 days. However, in the spirit of providing information that the Facility might find useful moving forward, the Monitoring Team reviewed the very late ISPA information, and offers the following comments. Although the IDT discussed the importance of communication and social skills, there was no evidence that the IDT reviewed the current status or progress (or lack thereof) in developing or utilizing alternative skills (replacement behaviors) as identified in the PBSP for Individual #288. That is, provided documentation (i.e., ISP Addendum dated 12/30/11) did not reflect active discussion of the replacement behaviors (i.e., "daily scheduling" and "tolerance training") as identified within the PBSP (dated 11/3/11) in place at that time. Of the three individuals reviewed, none (0%) of the individuals' teams adequately reviewed the biological/medical factors in a timely manner. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided (i.e., ISP Addendum dated 12/27/11), the IDT for Individual #240 discussed several biological/medical factors potentially related to challenging behavior. However, more specific discussion regarding the potential implications of these factors as related to the currently documented	

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		restraints would have been helpful. For example, one factor discussed was his nicotine dependence and subsequent challenging behavior when cigarettes are not available. However, the IDT did not identify whether or not this was a contributing factor in the current restraints and, if so, how this might be addressed by current behavioral programming. ▪ As noted above, the IDT for Individual #288 failed to conduct such a review in a timely manner. However, when the team eventually met, it provided documentation (i.e., ISP Addendum dated 12/30/11) for Individual #288 reflected active discussion by the IDT of several biological/medical factors that potentially influenced the demonstration of challenging behavior. It would have been important for these factors have been identified and addressed in a timely manner. ▪ According to documentation provided, the IDT for Individual #31 did not appear to meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, there was no evidence provided that the IDT adequately reviewed potential biological/medical factors associated with the identified challenging behaviors that led to restraint. Of the three individuals reviewed, none (0%) of the individuals' teams adequately reviewed the psychosocial factors in a timely manner. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided (i.e., ISP Addendum dated 12/27/11), the IDT for Individual #240 discussed several psychosocial factors potentially related to his challenging behavior. However, this review would have been more helpful if the IDT had attempted to draw implications from this past history to inform current or future behavioral programming. For example, one of the primary psychosocial factors described was his family history and related dysfunction. It would have been useful for the IDT to examine these factors as related to the recent behaviors (and resulting restraint) that appeared to have been triggered by a call from a family member. The potential resulting implications might have informed strategies included in subsequent PBSP. ▪ As noted above, the IDT for Individual #288 failed to conduct such a review in a timely manner. However, when the team eventually met, according to documentation provided (i.e., ISP Addendum dated 12/30/11), the IDT for Individual #288 discussed potential psychosocial factors potentially related to his challenging behavior. It would have been important for these factors have been identified and addressed in a timely manner. ▪ According to documentation provided, the IDT for Individual #31 did not appear to meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, there was no evidence provided that the IDT adequately reviewed potential psychosocial factors associated with the identified	

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		challenging behaviors that led to restraint.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, none (0%) of the individuals' teams reviewed the potential contributing environmental conditions. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided, the IDT for Individual #31 did not meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, there was no evidence provided that the IDT adequately reviewed potential environmental conditions associated with the identified challenging behaviors that led to restraint. ▪ According to documentation provided (i.e., ISP Addendum dated 12/27/11), the IDT for Individual #240 discussed potential environmental conditions and determined that there were no conditions in his home or work environments that appeared to contribute to the identified restraints. However, it appeared that a specific environmental condition (i.e., a call from a family member) was identified as the cause of the behavior that led to restraint. Indeed, subsequent ISPAs placed limits/restrictions on his access to unsupervised phone calls. Consequently, it appeared that the IDT missed an opportunity to discuss a contributing environmental factor related to his challenging behavior. Other examples can be found in subsequent ISPAs, including: access to preferred clothing and items (related to police), access to cell phones, etc. ▪ Technically, the team for Individual #288 did not meet in a timely manner to review the more than three restraints in 30 days. However, in the spirit of providing information that the Facility might find useful moving forward, the Monitoring Team reviewed the late ISPA information, and offers the following comments. According to very overdue documentation provided (i.e., ISP Addendum dated 12/30/11), the IDT for Individual #288 determined that there had been no environmental conditions or changes that appeared to be related to the restraints. However, according to content provided within the ISPA when compared with the ISPA template, there were several variables that might have been considered "environmental conditions" likely related to the behaviors that led to restraint. For example, his broken Compact Disc player was listed as the cause of his behavior that led to restraint (on 11/10/11), and this appeared consistent with "desired item … not available" as outlined on the ISPA template.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals reviewed, none (0%) of the individuals' teams reviewed and/or performed structural and/or functional assessments of the behavior provoking restraints. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided, the IDT for Individual #31 did not meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, there was no evidence that the IDT actively discussed the SFBA	Noncompliance

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		that was being developed as related to challenging behaviors that led to restraint. ▪ According to documentation provided (i.e., ISP Addendum dated 12/27/11), the IDT for Individual #240 reviewed the likely trigger as well as function of the target behavior that led to restraint. However, it was not evident that the IDT discussed whether or not the findings were consistent with the current SFBA, and/or if the IDT recommended further assessment. ▪ Technically, the team for Individual #288 did not meet in a timely manner to review the more than three restraints in 30 days. However, in the spirit of providing information that the Facility might find useful moving forward, the Monitoring Team reviewed the late ISPA information, and offers the following comments. According to documentation provided (ISP Addendum dated 12/30/11), the IDT for Individual #288 appeared to review the specific triggers associated with only two of the 19 restraints listed on the ISPA. In addition, it was not evident that the IDT discussed whether or not the findings were consistent with the current SFBA, and/or if the IDT recommended further assessment.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See Section C.7.c above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the	Of the three individuals reviewed, three (100%) individuals had a current PBSP at the time of the restraints. Of the three individuals in the sample who had PBSPs, the following was found based on a review of these PBSPs: ▪ Three (100%) specified the objectively defined behavior to be treated that led to the use of the restraints; ▪ One (33%) specified alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint. The following is an example where alternative, positive adaptive behaviors to be taught to replace the behavior that led to restraint was not adequately specified: o The PBSP for Individual #31 did not identify or define a replacement behavior. o Although the PBSP for Individual #240 identified a replacement behavior ("problem solving training"), the replacement was not adequately defined and would likely be difficult to accurately measure. In addition, the replacement behavior was clearly and conspicuously identified or defined in the staff instruction section of the PBSP. The current SPCIs of the individuals in the sample were reviewed. It should be noted that Individual #31 did not have a SPCI in place at the time of the sampled restraints. Provided documentation indicated that Individual #31 met the criteria for a safety plan	Noncompliance

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	restraint shall be set out in the individual's ISP;	on 3/6/12 (i.e., more than three restraints in a 30-day period), and that a SPCI was being developed. However, this plan was not currently available for review. Consequently, SPCIs for only Individual #240 and Individual #288 were available for review. The Safety Plans of the two of the three individuals in the sample were reviewed. The following represents the results: ▪ In two (100%), the type of restraint authorized was delineated; ▪ In two (100%), the maximum duration of restraint authorized was specified; ▪ In two (100%), the designated approved restraint situation was specified; and ▪ In two (100%), the criteria for terminating the use of the restraint were specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Similar to previous findings from the Monitoring Team's earlier reports, there was no evidence in the sampled documentation to indicate that treatment integrity was examined for any of the PBSPs of the three individuals selected.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Of the three records reviewed, there was no (0%) evidence that the individual's PBSP had been assessed or revised, as necessary. The following are examples of where teams failed to do this adequately: ▪ According to documentation provided, the IDT for Individual #31 did not appear to meet in response to the four restraints reported between 2/17/12 and 3/6/12. Consequently, no evidence was provided that the IDT adequately assessed and/or revised the PBSP. ▪ According to documentation provided (i.e., ISP Addendum dated 12/27/11), the IDT for Individual #240 determined that the current PBSP was "appropriate" and "practical." However, the IDT discussion regarding his replacement behaviors (i.e., "causal distance from others" and "tolerance") was not consistent with the replacement behaviors ("problem solving training") identified in the PBSP. As a result, the IDT did not appear to have an accurate discussion regarding the PBSP (i.e., regarding the effectiveness of replacement behavior). In addition, IDT opinion, not the use of actual data, was the basis for this determination. Consequently, it was not evident that the IDT had adequately reviewed the PBSP (dated 8/2/11) in place at the time of the restraints. ▪ Technically, the team for Individual #288 did not meet in a timely manner to review the more than three restraints in 30 days. However, in the spirit of providing information that the Facility might find useful moving forward, the Monitoring Team reviewed the late ISPA information, and offers the following	Noncompliance

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		comments. According to documentation provided (i.e., ISP Addendum dated 12/30/11), the IDT for Individual #288 determined that the current PBSP was "appropriate" and "practical." However, the IDT discussion regarding his replacement behaviors (i.e., "daily schedule" and "change of environment") was not consistent with the replacement behaviors ("daily schedule" and "tolerance training") identified in the PBSP. As a result, the IDT did not appear to have an accurate discussion regarding the PBSP (i.e., regarding the effectiveness of replacement behavior). In addition, IDT opinion, not the use of actual data, was the basis for this determination. Consequently, it was not evident that the IDT had adequately reviewed the PBSP (dated 11/3/11) in place at the time of the restraints. In order for compliance to be achieved in Sections C.7.a through C.7.g of the Settlement Agreement, when more than three restraints in a rolling 30-day period occur, significant improvement must be noted in team's active, data-driven, problem-solving discussion, and corresponding decisions related to the current and future programming (e.g., SFBA, PBSP, and SPCI).	
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 illustrated 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. According to policy, each incident of restraint was to be reviewed at the Unit meeting and the Incident Management Review Team meeting, within three business days. During the onsite monitoring visit, Incident Management Review Team meetings were observed and, during this timeframe, 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. However, the restraint checklists examined for Sample #C.1 documented that: ▪ Review and discussion occurred within thee business days in only 15 out of 24 (63%) of the restraint episodes. ▪ The Restraint Monitor completed debriefing forms, as required, in 22 out of 24 (92 %) of the incidents. ▪ There was evidence that the Director of Behavioral Services or his designee had reviewed each incident of restraint and had analyzed conformance with the requirements of the Settlement Agreement. ▪ In five incidents (21 %), the circumstances under which restraint were used was determined. Descriptions on the restraint checklists did not provide sufficient detail about the interventions attempted to avoid restraint. This information was critical for a thorough review of the circumstances leading to restraint.	Noncompliance

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		Based on the documentation provided, it could not be determined whether there was an adequate review by the IMRT of the 24 restraint episodes in Sample #C.1, or if all appropriate referrals were made to the teams. As noted above with the sample of individuals reviewed with regard to Section C.7, concerns that teams should have identified with regard to behavior support plans were not identified, and changes were not made to ensure that individuals were not subjected to unnecessary restraint. Often teams were not meeting, or meeting in a timely manner to address restraints, and when they did, the team discussion and action was inadequate. In order to provide a broader forum for the discussion of restraint use, in January 2012, the Restraint Reduction Committee was assimilated into the QA/QI Council. Data about the use of restraint was to be presented to the Council at regular intervals. During the Monitoring Team's onsite visit, recommendations were made during Committee meetings for the implementation of supported employment and other community-based initiatives to expand the range of individualized alternatives to restraint. The Facility was examining the obstacles to the implementation of these initiatives. However, since the last site visit, there appeared to be little change in the availability of such community-based opportunities, despite continuing evidence of the expressed interest of individuals who were the object of restraint episodes.	

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. (Section C.1)
2. Restraint Monitors should continue to 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. Prior to the use of restraint, staff should ensure they use replacement behaviors and/or coping strategies consistent with the PBSP. (Section C.1)
4. The Facility should ensure that all sections of the restraint report are completed. For example, dates should be recorded that reflect when direct support professionals were trained on PBSP and SPCI. (Section C.1)
5. Clear methodologies should be developed, implemented, and monitored to ensure that all staff, including "pulled" staff know which individuals cannot be restrained due to medical or other contraindications. (Section C.4)
6. The Facility should ensure that a licensed health care professional timely and regularly monitors, and appropriately documents, the vital signs and the mental status of an individual in restraints at least every 30 minutes from the start of the restraint, and for two hours after the restraint, except for a medical restraint that should be monitored pursuant to a physician's order. (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 nursing assesses and appropriately documents any restraint-related injury. (Section C.6)
9. Oversight continues to be needed to ensure that ISPAs are held following more than three restraints in a 30-day period. (Section C.7)
10. The Facility should continue to re-train QDDPs that facilitate IDT meetings and document on the revised ISPA template (when the IDT discusses the use of more than three restraints in a 30-day period) until they reach competency on adequately completing the meeting requirements and related documentation. (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 use 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: o **Review of Following Documents**: o LBSSLC Policies: "Incident Management: Abuse, Neglect or Exploitation [A/N/E]," revised 3/7/12; and "Reassigning Staff due to ANE," revised 3/7/12; o Sample #D.1 included a sample of 16 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: 40305394, 40353100, 40390916, 40523522, 40637296, 40760856, 40860898, 40887856, 40971536, 41008097, 41066917, 41078818, 41107457, 41130470, 41149897, and 41225444; o Sample #D.2 included a sample of 24 investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample #D.2 included cases: 12-045, 12-067, 12-073, 12-076, 12-078, 12-079, 12-080, 12-083, 12-087, 12-088, 12-092, 12-093, 12-094, 12-103, 12-106, 12-108, 12-116, 12-117, 12-121, 12-122, 12-10-043, 12-10-052, 12-11-061, and 12-11-075; o Sample #D.3 included Facility Investigations: 12-049, 12-056, 12-057, and 12-062; o Incident Management Review Team (IMRT) meeting minutes for each Monday since the Monitoring Team's last site visit; o Consultation Reports regarding Individual #239; o Individual Support Plans (ISPs) for Individual #264, Individual #31, Individual #143, and Individual #315; o List of Individuals (1) for Whom Adult Protective Services Conducts "Streamlined Investigations;" 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 45 employees; o Statements acknowledging reporting requirements for volunteers; o Training transcripts for 15 employees regarding training on the reporting of abuse, neglect, and exploitation; o Presentation Book for Section D; o Minutes of Quality Assurance/Quality Improvement Council meetings, dated 10/4/11 through 3/8/12; o List of individuals with Safety Plans; o Lists of injuries by individual and by type; o List of deaths, from 2009 to 2011; o List of incidents and injuries by living unit, from 9/11 through 2/12; o Trend Analysis Report for the Executive Safety Committee, dated 3/21/12;

	o Self-Advocacy Committee Minutes, from 10/6/11 through 1/30/12; and o Minutes of the Human Rights Committee (HRC), from 10/12/11 to 2/15/12. o **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs; o Melinda Voight, Risk Manager; o Rodney McWilliams, Incident Management Coordinator; o Juli Ann Brown, Lead Investigator; o Amanda Ellis, Investigator; o Tracey-Snow Murphy, Director of Residential Services; o Caleb Weston, Unit I Director; o James Clark, Unit II Director; o Heath Henry, Unit III Director; o Sheila Powell, Human Rights Officer and Individual #237; o Jim Forbes, M.Ed, BCBA, Director of Behavioral Services, and Carolyn Milton, BCBA; o Dawn Ripley, Director of Quality Assurance; and o Informal interviews/conversations with staff, foster grandparent, and individuals. o **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 3/19/12, 3/20/12, and 3/21/12; o Executive Safety Committee meeting, on 3/21/12; o Quality Assurance/Quality Improvement Committee meeting, on 3/21/12; o Human Rights Committee meeting, on 3/20/12; o Self-Advocacy Committee meeting, on 3/21/12; o Unit I meeting, on 3/20/12; and o Unit II meeting, on 3/21/12.
	Facility Self-Assessment: The Facility's review of its own performance found compliance with all provisions of Section D with the exception of those relating to the immediate reporting of serious incidents (D.2.a); the tracking of the reassignment of alleged perpetrators (D.2.b); the auditing of the reporting of significant injuries (D.2.i); the timeframes for the commencement of an investigation (D.3.e); the implementation of disciplinary or programmatic action (D.3.i); and the trending and tracking of unusual incidents and investigation results. The Monitoring Team's review also showed that the Facility was not in compliance with these provisions. Based on its review, the Monitoring Team also found non-compliance with the full requirements of D.2.e, specifically the education of individuals about the reporting of unusual incidents, with those of D.3.f, including the identification, by the Facility, of all previous investigations involving the alleged perpetrators,

	and D.3.g regarding supervisors' review of investigations. The Facility utilized random sampling for the evaluation of investigations. However, the sample size was small (15 cases). In addition, there did not appear to be consideration of current information regarding individuals involved in these investigations, including a review of their ISPs and ISPAs. Review of current information would permit the Facility to determine whether corrective actions implemented after the investigation report was received were sustained and had the expected impact. In its self-assessment, the Facility did not reference observation or analysis of conditions in the residential and programmatic units that might be contributory factors to the occurrence of abuse and neglect. Such considerations would have provided valuable information about the potential causes of serious incidents, as well as potentially effective corrective actions.
	Summary of Monitor's Assessment: The Facility's commitment to zero tolerance of abuse, neglect and exploitation, as well as the complete and timely investigation of serious incidents is both 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 and employee training and the more timely submission of investigations. It was significant that improper restraint use was investigated and determined to be physical abuse. The Facility provided evidence that abuse resulted in appropriate disciplinary action including termination from employment. In general, investigation reports continued to comply with the standardized format. However, concerns were noted with regard to DFPS and Facility investigators' review of the previous history of alleged perpetrators. Since the Monitoring Team's last site visit, the Facility Director had appointed an Incident Management Coordinator. He had begun to develop methods for the tracking and analysis of data. This work, in combination with that of the Risk Manager and the Director of Behavioral Services, had contributed to a greater understanding of the nature of serious incidents and allegations. Although it was recognized that additional work was necessary, this was a very positive step. The Facility's strenuous efforts to ensure that employees were fully trained in the requirements for the reporting of abuse, neglect, and exploitation was recognized and applauded by the Monitoring Team. Although significant work must be completed before Section D can be in full compliance with the obligations of the Settlement Agreement, the Facility continued to make substantial progress. The Facility should focus additional time and attention on the development and implementation of accurate databases; the analysis of trends by individual and by residential unit; the identification and replication of positive practices that have eliminated injuries and other serious incidents; expanded opportunities for individuals to exercise meaningful choice and thus avoid confrontations with staff; and additional training and/or supervision for Facility investigators so that their investigative skills can be further enhanced and the findings of their investigative reports strengthened.

#	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.	Since the last site visit, the Facility had reissued two policies relevant to the investigation of serious incidents. These policies reiterated that: ▪ Abuse and neglect of individuals would not be tolerated; and ▪ Staff must 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. As cited in previous reports, there was clear evidence that the Facility was working in good faith to implement the mandated policies. The Facility's leadership, including the Director of Residential Services and the Unit Directors, continued to set firm expectations regarding the prevention of abuse, neglect, and exploitation. In addition to the safeguards referenced in previous reports, such as the use of videotape footage, immediate reassignment of alleged perpetrators, and consistent disciplinary action, there was evidence that the discussion of serious incidents was increasingly focused on remedial or preventative strategies. Documentation reviewed for this report demonstrated that Interdisciplinary Teams were meeting more promptly to revise supports for vulnerable individuals. For example, the Team for Individual #184 met, on the same day as she experienced a serious fall, in order to put sufficient supports in place. All eighteen staff interviewed during the Monitoring Team's visit knew that abuse, neglect or exploitation would not be tolerated, and stated that they were familiar with reporting requirements. The reporting of incidents that occurred outside the range of the video cameras was indicative of the effectiveness of staff training as well as more stringent hiring practices.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for	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:	Noncompliance

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<tr><td></td><td>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.</td><td>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.

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.

It is important to note that since the Monitoring Team's last visit, the 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 Executive Safety Committee meeting conducted during the Monitoring Team's onsite visit. Documentation confirmed that injuries were tracked according to individual, type, cause, location, and shift. 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.

Although Document Request TX-LB-1108-III.16 was supposed to provide the numbers for each serious incident category, it did not. As a result, the following information summarized the data provided to the Monitoring Team:

<table>
<tr><th></th><th>1/1/11 to 6/30/11
(6 months)</th><th>7/1/11 to 1/1/12
(6 months)</th></tr>
<tr><td>Deaths</td><td>5</td><td>4</td></tr>
<tr><td>Serious Injuries</td><td>24</td><td>10</td></tr>
<tr><td>Sexual Incidents</td><td>2</td><td>Not provided</td></tr>
<tr><td>Suicide Threat (credible)</td><td>1</td><td>Not provided</td></tr>
<tr><td>Unauthorized Departure</td><td>20</td><td>Not provided</td></tr>
<tr><td>Choking</td><td>1</td><td>Not provided</td></tr>
<tr><td>Other</td><td>6</td><td>Not provided</td></tr>
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		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 were responsible for developing these plans/supports, and they were documented in the Individual Support Plan Addenda. Efforts had been initiated to analyze the causes of falls, and remedial actions were beginning to be implemented. Discussion at the Incident Management Review Team meetings was noted to be more thorough, more cognizant of the completion of recommended actions, and increasingly focused on Facility-wide issues that required attention. Although significant improvement was seen since the Monitoring Team's earlier reviews, analysis of the data regarding the allegations of abuse, neglect, and exploitation would benefit from additional refinement. For example, documentation provided to the Monitoring Team indicated: ▪ There were 468 allegations of abuse, including 103 that were substantiated (22%); 237 that were unsubstantiated (51%); and 28 that were inconclusive (6%). ▪ There were 144 allegations of neglect. Of these, 58 were confirmed (41%), 80 were unconfirmed (55%), and six allegations were inconclusive (4%). ▪ There were zero allegations of exploitation. As discussed further below, the Facility has begun to strengthen its data collection capacity. The statistics above reflect the Facility's focus on obtaining accurate information about risks in this environment. As the Facility proceeds with these efforts, further analysis will be critical to the implementation of additional means to ensure protection from harm. Based on an interview of 18 staff responsible for the provision of supports to individuals, 18 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on an interview of 18 staff responsible for the provision of supports to individuals, 18 (100%) were able to describe the reporting procedures for other serious incidents. Two samples of investigations were selected for review. These included: ▪ Sample #D.1 which included a sample of 16 DFPS investigations of abuse, neglect, and/or exploitation. This sample included the following investigation numbers: 40305394, 40353100, 40390916, 40523522, 40637296, 40760856, 40860898, 40887856, 40971536, 41008097, 41066917, 41078818, 41107457,	

#	Provision	Assessment of Status	Compliance
		41130470, 41149897, and 41225444; and ▪ Sample #D.2 which included a sample of 24 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: 12-045, 12-067, 12-073, 12-076, 12-078, 12-079, 12-080, 12-083, 12-087, 12-088, 12-092, 12-093, 12-094, 12-103, 12-106, 12-108, 12-116, 12-117, 12-121, 12-122, 12-10-043, 12-10-052, 12-11-061, and 12-11-075; In addition to the investigation reports contained in Sample #D.1 and D.2, additional incident reports were selected for review. Sample #D.3 included Facility investigations 12-049, 12-056, 12-057, and 12-062. Based on a review of the 40 investigation reports included in Sample #D.1 and #D.2: ▪ Of the applicable investigations reviewed, 18 out of 28 (64%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Based on information included in the investigation files, individuals filed seven reports. These incidents of delayed reporting were not included in the percentage cited here, because there was no requirement that individuals report timely. In addition, there were five investigations in which the time of occurrence was unknown and timeliness, therefore, could not be determined. Investigation reports that documented delays in reporting included: 12-11-75, 12-116, 12-094, 40637296, 40353100, 40523522, 41107457, 41066917, 41149897, and 41130470. ▪ 40 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. Sample #D.3 consisted of four investigation reports reviewed by the regulatory agency. ▪ Three of these reports concerned the deaths of individuals. The deaths were reported in accordance with policy. The fourth investigation report (12-056) examined the very serious injury (i.e., one individual biting off a piece of ear of another individual) experienced by Individual #84. This incident was responded to as warranted given its emergency nature. The Campus Coordinator began the investigation, by photographing the injury, within fifteen minutes. ▪ Four (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. The Facility used 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	

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		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 the review of the one non-death related investigation in Sample #D.3, the requirements for the use of a standardized reporting format also was met. Due to the delays in reporting identified in the review of investigation reports, the Facility remained out of compliance with this provision. This was consistent with the Facility's finding in its Self-Assessment.	
	(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," reissued on 3/7/12, 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 was completed, and they were cleared. Alleged perpetrators were assigned administrative or foodservice tasks. Since the Monitoring Team's last onsite visit, the Facility had begun to track the date of return to duty or the final action, if any, taken against the employee. However, during the current onsite visit, the Incident Management Coordinator was continuing to address the accuracy of the report. Some data had not yet been entered or updated. Nonetheless, progress was being made with this requirement. An Allegation Tracking Log had been designed and was organized by incident, alleged perpetrator, where the alleged perpetrator was assigned, the outcome of the investigation, and the date on which the alleged perpetrator was released to return to duty. The progress of this initiative will be reviewed again during the Monitoring Team's next visit to corroborate its timeliness and comprehensiveness. As stated in previous reports, 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 not be confirmed that the staff that had been removed from direct contact, and 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.	Noncompliance

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		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 Individual 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. The Facility reported that there had been no changes in the training curricula since the Monitoring Team's last review. As reported in the last report, 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 Quality Assurance staff's monitoring visits; ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. The Facility provided documentation for 15 staff selected randomly from the current list of employees. Review of records indicated that these 15 staff (100%) had completed competency-based training on abuse and neglect either prior to working directly with individuals or as part of their annual refresher 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 indicated that the Facility was in 100% compliance. During the informal visits to the living units, direct support and clinical professionals were queried about the process of reporting allegations of abuse, neglect, exploitation, or other serious incidents and their comfort level with these obligations. At least three employees had reported an allegation and confirmed that the process worked as	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		expected with the exception of delays in intake. Delays in intake were reported to be as long as 45 minutes, creating a hardship for the reporter who was expected to be on duty. All (100%) of these staff could describe reporting procedures accurately. 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 45 employees was selected for review. All (100%) of the employees reviewed had evidence of the acknowledgement of the obligation to report located in their personnel records. All 18 employees queried informally about this obligation were able to describe their responsibility. As part of the pre-review document request, the Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. There was no documentation provided to the Monitoring Team regarding employees failing to report or disciplinary action against employees who failed to report.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	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. Information was provided regarding the methods for reporting of any allegations. Correspondents were asked to acknowledge receipt of this information. The Incident Management Coordinator was responsible for tracking this information. He maintained a notebook where signed statements were kept. The Facility stated that it also utilized the annual ISP meetings to educate individuals, primary correspondents, and LARs about the means to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation. ISPs were examined for Individual #264, Individual #31, Individual #315 and Individual #143. With the exception of the ISP for Individual #264, there was no information regarding education about the reporting of unusual incidents in any of these documents. Individual #315 was described as "possibly…able to indicate something was wrong." In the ISP for Individual #143, the space under the heading Rights/Risks/Protections was blank. In addition, while onsite, members of the Monitoring Team attended the ISP meetings for Individual #98, Individual #259, and Individual #51. None of the ISP	Noncompliance

#	Provision	Assessment of Status	Compliance
		meetings observed included a discussion or distributed handouts addressing Abuse/Neglect. ISPs had begun to show that teams were reviewing incidents and allegations. However, detailed information about investigations, including copies of the investigation report or a summary of relevant facts, 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 and to move beyond only listing the specific incidents or injuries experienced by the individual. This is discussed in further detail with regard to Section F of the Settlement Agreement.	
	(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. With the exception of the poster in the workshop, the posters were visible and placed at the appropriate eye level. 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. However, at least two employees stated that their usefulness was very limited. The Facility might want to consider redesigning the poster or providing additional instruction to staff on its possible use. Development of educational materials regarding a "right of the month" also might encourage staff to discuss the exercise of rights with the individuals who reside at LBSSLC. 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. During the site visit, the agenda for the Self-Advocacy Group included a discussion of future visits to community-based residential options and preparation for voting in the upcoming elections.	Substantial Compliance

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		The "Mustang Aktion Club" continued to involve its members in community-based volunteer projects. Outreach to people who were homeless was the most recent initiative of the Club.	
	(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. According to the information received through interviews, there were no investigations currently under review by law enforcement agencies. There was evidence that the Office of the Inspector General (OIG) was notified in appropriate cases. For example, the DFPS report for 41078818, in which the physical abuse of Individual #322 was investigated, resulted in dismissal for the employee confirmed for abuse. The OIG was appropriately involved, but failed to find any criminal activity in this incident.	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, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	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, 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. Based on interviews with the Director, the Incident Management Coordinator, two Facility Investigators, three Unit Directors and 18 employees, no staff had reported a fear of retaliation or knew of such fear in another person. Based on the examples provided in the Monitoring Team's last report, the prohibition against retaliation was emphasized in the orientation and other classes regarding the reporting of abuse, neglect, and exploitation. Employees were instructed that retaliation would not be tolerated either on or off the grounds of the Facility. The introduction of a new poster with that message was prominently displayed throughout the Facility. This emphasis related to retaliation also not being tolerated off the grounds of the Facility was	Substantial Compliance

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		responsive to information the Monitoring Team included in its last report regarding a staff member raising this question. The Facility's responsiveness to this showed its commitment to ensure that staff felt comfortable in reporting allegations. Based on a review of 41 investigation files (the 40 investigations in Samples D.1 and D.2, plus the one non-death related investigation in Sample #D.3), 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 Incident Management Coordinator reported that the Incident Management database was 85% complete in terms of the entry of accurate information. The Monitoring Team will review the Facility's progress in this regard during upcoming reviews.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents 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,	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	Substantial Compliance

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	including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	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 investigators were generally determined to be adequate. The APS Facility Instructor Led Skills Development (ILSD) curriculum contained excellent information regarding aspects of the investigation process as well as competency-based tests and quizzes. It was not clear from reviewing the curricula itself whether there was specific instruction regarding the review of past investigations pertaining to the subject of the investigation. Based on the State's comments to the draft report, APS state office trained all field staff on this requirement, and will incorporate this requirement into ILSD curriculum this spring. ▪ DFPS provided transcripts regarding the training provided to its seven investigators. According to the information provided, all investigators (100%) had received training in fundamentals of investigations, and in working with people with an intellectual disability. ▪ 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 Incident Management Coordinator did not conduct investigations. A fifth Campus Coordinator had been hired to provide additional Incident Management presence. His training requirements were to be completed by April 30, 2012. He had already completed training in the fundamentals of investigations and in working with people with a developmental disability.	

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		As referenced above, there was documentation that improper restraints were being investigated by DFPS as physical abuse (i.e., Investigations 41107457 and 41149897). Three Campus Administrators were trained as Restraint Monitors to assist and obtain an Incident Management perspective of restraints. The remaining two Campus Administrators were scheduled to receive this training as soon as possible. This cross-training is to be commended, as is the full investigation of improper restraint use and the implementation of appropriate disciplinary action. In the improper restraint of Individual #213, two staff were dismissed from employment and one employee was cited for failing to seek timely assistance.	
	(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 contained this instruction. However, it was not applied in any of the investigations reviewed during this site visit. 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. In an effort to increase interagency collaboration, the Director of LBSSLC had continued to convene quarterly 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 relationships with DFPS, local law enforcement, and the OIG were described in positive terms. DFPS had offered and had conducted training on the use of excessive force in response to incident investigations where staff failed to show appropriate interaction with individuals. In 40637296, an employee was dismissed for physical abuse as a result of carrying/pulling Individual #146 from the kitchen area. The finding for 40887856 was inconclusive. However, the staff person was to be retrained due to the possible aggressiveness noted, but not entirely clear, in the video footage.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The 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,	Substantial Compliance

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		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. Based on a review of the investigations completed by DFPS and the Facility for this report, the following was found: ▪ Of the 16 investigation records from DFPS (Sample #D.1), although there was notification to law enforcement in five cases, there was no indication of direct involvement by the law enforcement agencies. The investigations with notification included: 41149897, 40887856, 4039916, 40305394, and 40353100. (One investigation report, for 41107457, was missing the page with this information.) ▪ Of 24 investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies because of the nature of the incident (e.g., falls, medication error, injuries of determined cause without suspicion of abuse or neglect, sexual incident between peers, unfounded allegations, etc.). Discussion with the investigators and the Incident Management Coordinator indicated a high level of cooperation between the Facility and law enforcement agencies.	
	(d) Provide for the safeguarding of evidence.	As reported previously, 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. Documentary evidence (i.e. copies of individuals' records, photographs, etc.) was stored in locked cabinets in the Incident Management offices. Only the Incident Management Coordinator and the Lead Investigator had keys to these cabinets. Based on a review of the investigations completed by DFPS (Sample #D.1) and by the Facility (Sample #D.2), no investigations 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	Substantial Compliance

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		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.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Both the DADS policy and the LBSSLC policies cited above required that investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. In order to determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of 16 DFPS investigations: ▪ Sixteen (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. Based on the Monitoring Panel's discussions with DFPS in December 2010 and June 2011, DFPS developed a format to better document activities that occur within the first 24 hours of the investigation. This information was evident in the documentation reviewed during this site visit. It consisted, for example, of the DFPS investigator contacting the Campus Administrator to begin the collection of documents. ▪ Fifteen out of sixteen investigations were completed within 10 calendar days of the incident, including sign-off by the supervisor. The remaining investigation report (41149897) included a copy of the written request for an extension. This investigation was complex and included citation of failure by the Facility to ensure proper authorization for restraint. Therefore, there was 100% compliance with this requirement.	Noncompliance

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		▪ All investigations (100%) resulted in a written report that included a summary of the investigation findings. ▪ In six of the investigations (38%) reviewed, recommendations for corrective action were included. In these investigations, the recommendations were adequate to address the findings of the investigation. Although there was a notable increase in the presence of recommendations, primarily related to the need for additional training, 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 Monitoring Team's last review, 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 24 Facility investigations: ▪ Twenty-one out of 24 (88%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. The following are examples of the investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: o Investigations 12-067 and 12-08, regarding physical abuse; o Investigations 12-076, 12-112, and 12-121 regarding verbal abuse; o Investigations 12-079, 12-108, and 12-107 regarding serious injuries. The three investigations that were not started within the first 24 hours or sooner, if necessary, included: 12-083, 12-11-075, and 12-073. ▪ Fifteen out of 24 were completed within 10 calendar days of the incident,	

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		including sign-off by the supervisor, and three extensions were requested and granted for reasonable circumstances (75%). Six investigations did not have written extensions (i.e., 12-10-043, 12-076, 12-079, 12-121, 12-106, and 12-11-061); ▪ All but three investigations (12-121, 12-092 and 12-073), or (88%) resulted in a written report that included a clear summary of the investigation findings. ▪ In 15 of the 24 investigations reviewed (53%), relevant 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 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	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. However, although 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. 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	Noncompliance

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	investigator's findings; and the investigator's reasons for his/her conclusions.	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 16 out of 16 (100%), each serious incident or allegations of wrongdoing; o In 16 out of 16 (100%), the name(s) of all witnesses; o In 16 out of 16 (100%), the name(s) of all alleged victims and perpetrators; o In 16 out of 16 (100%), the names of all persons interviewed during the investigation; o In 16 out of 16 (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 16 out of 16 (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. All of the DFPS reports stated: "The prior case history of principals was reviewed and not used in the current case because it was deemed not relevant." This blanket statement provided no analysis of the facts (i.e., whether there were previous allegations for the alleged perpetrator). It would be clearer if this information were included in the investigation report. 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. o In 16 out of 16 (100%), the investigator's findings; and o In 16 out of 16 (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	

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		serious incidents: ▪ In 21 out of 24 investigations reviewed (88%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The investigations that did not include an adequate basis were: 12-121, 12-092, and 12-073. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 24 out of 24 (100%), each serious incident or allegations of wrongdoing; o In 24 out of 24 (100%), the name(s) of all witnesses; o In 24 out of 24 (100%), the name(s) of all alleged victims and perpetrators; o In 24 out of 24 (100%), the names of all persons interviewed during the investigation; o In 24 out of 24 (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 24 out of 24 (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 21 out of 24 (88%), the investigator's findings; and o In 21 out of 24 (88%), the investigator's reasons for his/her conclusions. The DFPS investigations were more comprehensive and more clearly articulated in their reasoning than those conducted by the Facility. A finding of noncompliance has been made due to issues related to the basis for the findings some of the Facility's investigations, as well as concerns noted in both DFPS and Facility investigations related to the use of "all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency."	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff	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 Facility investigation was complete, and that the report itself was accurate,	Noncompliance

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	supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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. As observed during the site visit, the recently appointed Incident Management Coordinator now played a critical role in this process of review. Over the course of the site reviews, LBSSLC had implemented an increasingly comprehensive process for the review of investigations. Although instances were noted where timely review had not been documented in the record and instances in which an adequate basis for the findings was missing, the overall structure for an appropriate review was beginning to be implemented and refined 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. Careful and consistent follow-up was noted during those meetings conducted during the site visit. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 16 out of 16 investigation files reviewed, there was a notation that a supervisor had reviewed the report. However, there was nothing in the record to provide detail on the nature of the supervision, or how many errors were corrected due to that supervision. However the reports appeared reasonably thorough, complete, and accurate. ▪ 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. The Facility Director had requested a review of the investigation finding for 41149897. This matter was still under review at the time of the site visit. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 24 out of 24 (100%) investigation reports reviewed, evidence was found that the supervisor had conducted a timely review of the investigation report. LBSSLC has initiated a multi-faceted review process and this oversight was evident in the investigations reviewed in Sample #D.2. Specifically, on a	

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		supervisor's review pages, feedback in the form of notes and comments was included. In addition, the IMRT minutes stated that a review had occurred and, when appropriate, that next steps were being taken. As noted above, DFPS investigations did not provide evidence of the nature of the supervision provided. As has been discussed with the parties, a signature is not adequate evidence of supervisory review. The Monitoring Team appreciates that State's willingness to propose an alternative. However, a finding of noncompliance has been made due to this deficiency.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility's compliance with the completion of investigations for serious incidents is discussed in detail with regard to Section D.3.f.	Noncompliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	In its investigation report files, the Facility included copies of correspondence related to disciplinary action. The review of 40 files in Samples #D.1 and #D.2 indicated the termination of employees confirmed to have committed abuse or neglect. As recommended during the Monitoring Team's last review, the Facility had begun to track the reassignment of alleged perpetrators and any ensuing disciplinary actions. During the months of January and February 2012, ten employees were terminated. The lack of a reliable tracking mechanism, as identified by the Facility itself, has led to the finding of noncompliance. For 33 out of 40 of the applicable investigations reviewed (83%), prompt and thorough programmatic action had been taken and documented. For example, the following programmatic actions had been taken: ▪ There was a careful and sensitive review of staff training needs after Individual #124 alleged that staff spat on him. Staff were trained on the symptoms of hallucinations and on appropriate interactions with individuals. ▪ In each of the incidents where the reporter was an individual, the results of the investigation were explained and the individual was given an opportunity to respond. ▪ There was a very careful review documented and counseling supports implemented after a sexual incident involving two peers. Staff showed sensitivity and a reassuring demeanor in addressing the issue. ▪ The improper restraint of Individual #213 not only resulted in disciplinary action, but in a complete restructuring of the protocols for the display of and reference to the Do Not Restrain Lists.	Noncompliance

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		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 neglect was not found when Individual #43's seatbelt was not fastened, and he slipped from his chair and fractured his hip. Similarly, neglect was not cited when there was a failure to identify the need for the appropriately sized mat next to the bed of Individual #217. He experienced a serious injury when he fell from his bed. Even though neglect was not found in these two incidents, more thorough programmatic actions should have been developed and implemented based on the information in the investigations, but they were not. ▪ Although there was sensitivity in reviewing the unfounded allegations of Individual #154, there was no indication of a thorough re-examination of the reasons for his anger at staff. There was no evidence of a substantially different approach to working with him. Although there continued to be environmental and programmatic issues of serious concern at the Facility, the Facility is to be commended for the multiple initiatives it had begun to implement to review investigation reports, and to develop programmatic interventions, as appropriate. The review of the minutes of Incident Management Meetings documented the attention to follow-up at the unit and Facility levels. Although additional work is required to reach compliance, it was evident that attempts to recognize and address areas of continuing concern were being made by the leadership staff. For 33 out of 40 applicable investigations (83%), 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: ▪ Ten staff were terminated as a result of findings from the investigations where abuse and/or neglect was confirmed. ▪ The protocols governing the Do Not Restrain List were revised and mechanisms to monitor compliance with these requirements were being instituted throughout the Facility. The following are examples of outcomes that did not appear to have been achieved through the implementation of the programmatic and/or disciplinary action: ▪ As described above, there was no evidence of the redesign of key programmatic strategies for individuals, such as Individual #213 and Individual #7, who report unfounded allegations.	

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	(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 Monitoring Team's last review, 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. An expansion of storage space was being considered, but the details of this plan had not been finalized.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	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 2011, a statewide Avatar database was implemented. This new system was proving to be very useful in the systematic collection and retrieval of important information despite some technical problems. 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 according to 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 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. Although critical information was now being identified, the actual trending of investigations had not been implemented. In part, this was a result of instability in the Incident Management Coordinator position, the lack of a database, and the lack of confidence in the reliability of data. Although the current and knowledgeable Incident Management Coordinator had begun to implement some steps, the system still required the completion of a database. The lack of a reliable tracking and trending system was identified in the Facility's self-assessment of this provision. 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, additional progress will be evident.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a	Substantial Compliance

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	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.	different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. 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 conducted its annual employee registry check and criminal history submission in October 2011. Also, the Facility submitted documentation indicating that background checks were conducted on volunteers. No active employees had been terminated based on the results of background checks conducted in the fall of 2011. A random sample of 28 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. As reported during the previous site visit, 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.	

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

1. The Facility should finalize and maintain its Allegation Tracking Log in order to organize by incident the name of the alleged perpetrator, where the alleged perpetrator was assigned, the outcome of the investigation, and the date on which the alleged perpetrator was released to return to duty or other personnel action was taken. (Sections D.2.b and D.3.i)
2. 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)

3. With regard to appropriate follow-up for investigations:
    a. The State, including DADS and DFPS, and the Facility should continue to 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 continue to 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 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)
6. The findings from the Risk Manager's intensive review of incidents should continue to be followed-up 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 be 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)

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

1. The Facility might want to consider redesigning the poster regarding individuals' rights or providing additional instruction to staff on its possible use. Development of educational materials regarding a "right of the month" also might encourage staff to discuss the exercise of rights with the individuals who reside at LBSSLC. (Section D.2.f)
2. Training of staff should continue to 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. The Facility should continue to utilize creative approaches, such as the new poster emphatically expressing the prohibition of retaliation, in its efforts to educate and reassure staff. (Section D.2.h)

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: o **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 DADS Policy Number 003.1: "Quality Assurance," dated 1/26/12; o Quality Assurance/Quality Improvement Council meeting minutes, dated from 10/4/11 to 3/8/12; o LBSSLC Policy "Review Processes: QA Assurances Process/Plan," dated 3/7/12; o Plan of Improvement/Self-Assessment, updated on 2/29/12; o Quality Assurance Plan, revised 1/30/12; o Completed monitoring forms, with various dates, including the monitoring of lifting forms completed between 10/11 and 1/12; and o Presentation slides from the H&W Independent Solutions QE and Departmental Workshop, "QA/Q1 Planning, FY12." o **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, Incident Management Coordinator. o **Observations of**: o Executive Safety Committee meeting, on 3/21/12; o Incident Management Review Team meetings, on 3/19/12, 3/20/12 and 3/21/12; and o Quality Assurance/Quality Improvement Council meeting, on 3/21/12.
	Facility Self-Assessment: The Facility's Self-Assessment was updated on 2/29/12. For Section E of the Settlement Agreement, with the exception of Section E.3, the Facility had determined that it was not in substantial compliance with the requirements of the Settlement Agreement. Section E.3 required the dissemination of Corrective Action Plans to those responsible for their implementation. This was consistent with the Monitoring Team's findings. The Facility provided an analysis of a number of the action steps taken to achieve compliance with the provisions in this Section. The Facility had begun to incorporate data to substantiate its findings of compliance or noncompliance. These were positive steps. However, the Facility's Self-Assessment for Section E did not adequately address all of the requirements of the Settlement Agreement. For example, some of the concerns related to the self-assessment activities, included the following: ▪ Many of the self-assessment activities for Section E.1 related to the activities of the QA/QI Council. While these were important activities and an essential component of the Facility's Self-Assessment,

	Section E.1 requires the development of activities to: "Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports." The Facility's self-assessment should address not just the QA/QI Committee's responsibilities in this regard, but the overall processes the Facility uses to accomplish this goal (e.g., monitoring activities, development and implementation of outcome and process measures, ongoing activities with the various departments to analyze data, etc.). ▪ Although the Facility placed some focus on measuring the quality of the initiatives for Section E (e.g., whether the action plans included measurable objectives), it will be particularly important to assess quality across the realm of initiatives, as well as the timeliness of them. For example, issues such as the reliability and validity of data being collected would be important self-assessment measures for Section E, as would the quality of the implementation of corrective action plans.
	Summary of Monitor's Assessment: Information derived from interviews and from the documentation examined during and after the onsite review confirmed that since the Monitoring Team's last visit, the Facility had taken significant actions to strengthen the Quality Assurance process. Clearly, the design and implementation of an effective and sustainable Quality Assurance process was a priority. The Facility had made a notable commitment to utilize appropriate and effective monitoring and evaluation strategies in achieving compliance with the outcomes of the Settlement Agreement. It was apparent that the QA/QI Council had become a relied-upon partner in the efforts to reach compliance with the requirements articulated in Section E. Data regarding the specific areas the Settlement Agreement covered were discussed routinely at the Council meetings. Subcommittees were formed to address particular concerns. CAPs were identified and tracked. A second direct support professional had been added to the Council to ensure needed input from and outreach to the staff working closest to the individuals residing at LBSSLC. During the site visit, candid discussions with key staff confirmed that there were still unresolved concerns about the monitoring processes being conducted under the aegis of the Quality Assurance Department. For example, there continued to be a lack of establishment of inter-rater reliability. This longstanding problem was recognized, but had not been fully addressed. Inconsistent and incomplete instructions for the completion of monitoring forms undermined the Facility's attempts to develop and sustain reliable evaluation methodologies. The Facility's sincere efforts to improve the quality of its monitoring strategies sometimes were impeded by staff vacancies in the various departments and shifting priorities. Timelines for responding to cited deficiencies were extended without sufficient explanation. The development and implementation of a strengthened process for addressing programmatic and environmental deficiencies continued to evolve. Seven CAPS were being tracked at the time of the site visit. In addition, nine workgroups had been established to address/improve recurrent systems. The CAP Tracking Log had been revised to include the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. Potential barriers to the implementation of a CAP should be more clearly defined. The exploration of barriers might assist with the establishment of

	realistic timeframes. Since the Monitoring Team's last onsite review, data collection and analysis had become more detailed. Discussions about the data were noted in several forums, including the QA/QI Council, the Incident Management Review Team meetings, and the Executive Safety Committee. The newly appointed Incident Management Coordinator had made substantial effort to aggregate facts about incidents and incident investigations, and was beginning to develop reliable reports on trends. The establishment of workgroups and committees to further analyze data and trends was noteworthy. The workgroup formed to review the trends identified from the analysis of incidents had begun to develop remedial strategies, including in-service training, for those residences with higher rates of incidents. The Facility had expended considerable effort in its ongoing plans to develop and track outcome measures. This initiative will continue to require close collaboration between the clinical/professional Departments and the Quality Assurance staff. It was the Monitoring Team's assessment that the Facility had identified data that was being or could be collected. However, actual key indicators and/or outcome measures had not yet been developed. In order for this to occur, the data needed to be linked to the Facility's programmatic goals, such as health, safety, and meaningful lives for the individuals who reside at LBSSLC. Then, the Facility needed to set goals and collect data to determine if such goals were being met. Part of this process would be the establishment of baseline data and benchmarks. The decisions about benchmarks are important. They will be influenced by, and should consider, external and internal data and expectations, as well as the Facility's resources, staff expertise, the design of the campus, community resources, just to name a few. In addition, such a system should include measures and strategies for qualitative evaluation of the progress made by individuals who reside at the Facility. Such progress might be evidenced by growth in independence, social skills and the ability to exercise meaningful choice. These can all be incorporated into an outcome management system. As the Facility continues its efforts to finalize these outcome measures, the Monitoring Team recommends an incremental approach to implementation so that any necessary adjustments can be made effectively and in a timely manner. The development of process and outcome measures and benchmarks will be instrumental to the design of the monitoring protocols. Although numerous completed monitoring forms were submitted, and although the summaries of the monthly monitoring results provided useful information, more detailed analysis of the monitoring conducted by the Departments and by the Quality Assurance staff 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 management staff have targeted for improvement, etc. In addition, the development of reliable key indicators and outcome measures will necessitate strengthening the methodology used in the Quality Assurance efforts. 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.

	In summary, considerable progress in the development of a strong Quality Assurance system was evident during this site visit. The Monitoring Team commends the Facility's efforts in striving to achieve compliance with these mandates of the Settlement Agreement.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	As discussed in previous reports, 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. DADS Policy Number 003.1, issued on 1/26/12, required the development of a set of key indicators. However, the policy did not define those indicators or provide specific direction for their definition. The Facility's Quality Assurance Department and the Directors of the various clinical/professional Departments began drafting indicators or outcome measures under the aegis of the QA/QI Council. The status of this initiative was reviewed during the site visit. A final set of key indicators had not been established pending review and revisions from the membership of the QA/QI Council. Their comments were due by 4/1/12. As discussed above, this initiative requires continuing collaboration and a measured approach to implementation. It was the Monitoring Team's assessment that the draft "outcome measures" developed to date were essentially a listing of the data that either was available or could be collected in relation to the various areas of service provision. They did not yet represent key indicators or outcome measures. In order to take this next step, the Facility needed to identify its overall programmatic goals (e.g., individuals will be safe, individuals will lead meaningful lives, individuals will be involved in their communities, etc.). The data then needed to be linked to the Facility's programmatic goals, and data collected to determine if such goals were being met. In developing such a system, key indicators should be developed and monitored regarding the wide range of supports the Facility provides, including areas such at-risk individuals; medical, psychiatric, and nursing issues; infection control; physical and nutritional supports; residential and vocational supports; habilitation and skill acquisition; and outcomes related to transition to the most integrated setting. The data should be used to determine if the Facility is actually reaching clearly delineated benchmarks related to health, safety, and integration. If not, then analysis needs to occur to determine the changes that should be instituted to assist the Facility, and, most importantly, the individuals in reaching the desired outcomes.	Noncompliance

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		The monitoring processes and the monitoring tool were being reconsidered as part of the initiative to develop key indicators. The development of key indicators, including process and outcome measures and benchmarks will be instrumental to the design of the monitoring protocols. The prioritization and streamlining of monitoring to ensure its sustainability and its usefulness in improving protections, and services/supports was to be completed by the end of August 2012. As discussed while the Monitoring Team was on site, it will be essential to determine where data from other sources could be used to measure the indicators, how that data would be validated, and where monitoring (either at the program level, or at the QA Department level) would be necessary to collect the data needed to either provide the data for the indicators/outcomes and/or provide another source of important quality assurance/improvement information. Monthly monitoring was conducted in a collaborative manner between the clinical/professional departments and the Quality Assurance staff. However, it was noted that monitoring for Sections O, P, and R had been put on hold pending the filling of staff vacancies. 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 monitoring the Departments and the Quality Assurance staff conducted 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. In addition, the development of reliable key indicators and outcome measures will necessitate strengthening the methodology used in the Quality Assurance efforts. For example, inter-rater reliability continued to be inconsistent. Efforts to establish inter-rater reliability across monitors were not yet completed. According to documentation provided, a procedure detailing the inter-rater reliability process was to be approved by the Director of Quality Assurance by 7/3/12, and staff would be trained in the newly developed protocols by 8/31/12. The Facility recognized that part of the development of key indicators and outcomes measures was the development of clear instructions for how data would be collected. As has been noted in the Monitoring Team's previous reports, the same was true for monitoring tools. Each tool should have clear instructions to ensure that various staff responsible for their implementation were using the same methodology for conducting monitoring, as well as the same standards in the evaluation process. 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. It was apparent that the QA/QI Council had become a relied-upon partner in the efforts	

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		to reach compliance with the requirements articulated in Section E. For example, data regarding injuries, incidents and restraint use were discussed routinely at the Council meetings. In addition, each of the Settlement Agreement sections was discussed on a rotating basis during Council meetings. From both the Monitoring Team's observations of a Council meeting during the week of the onsite review, as well as review of minutes, this review was data-driven. Although, as noted elsewhere, problems continued to exist with regard to the reliability and validity of some of the data, the Council was making use of the data to critically analyze the protections, supports, and services it provided. The identification of systemic problems resulted in subcommittees or workgroups charged with providing a thorough analysis of the barriers to expected performance. Root cause analyses were implemented regarding environmental and programmatic concerns in certain residential areas. Problems identified in reports from the Monitoring Team, such as the failure of nurses to monitor restraints within a thirty-minute timeframe, or ones that the Facility identified, such as concerns with infection control issues, active treatment, medication errors or use of excessive force, were examined and, as appropriate, referred to Department heads for resolution. CAPs were identified and tracked. A second direct support professional had been added to the Council to ensure needed input from and outreach to the staff working closest to the individuals residing at LBSSLC. Although the Facility acknowledged, and the Monitoring Team concurred, that substantial work remained, progress in the requirements of this provision was noted during the site visit.	
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 continued to establish processes and protocols to collect data through various monitoring activities conducted collaboratively by the Quality Assurance Department and the clinical/professional staff in the various Departments. Since the last site visit, data collection and analysis had become more detailed in some areas. Discussions about the data were noted in several forums, including the QA/QI Council, the Incident Management Review Team meetings, and the Executive Safety Committee. The newly appointed Incident Management Coordinator had made substantial effort to aggregate facts about incidents and incident investigations and was beginning to develop reliable reports on trends. The Director of Behavioral Services, the Risk Manager, and the Incident Management Coordinator now collected information that would benefit from a coordinated approach to the analysis and discussion of the facts about restraint use, injuries, and serious reportable incidents. The establishment of workgroups and committees to further analyze data and trends was noteworthy. The workgroup formed to review the trends identified from the analysis of incidents had	Noncompliance

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		begun to develop remedial strategies, including in-service training, for those homes with higher rates of incidents. Attention was paid to recurring problems identified in reports from the Monitoring Team or from the Facility's self-monitoring reports. For example, the failure of nurses to respond to a restraint episode within thirty minutes resulted in a revision to the process for contacting nurses and dispatching them to the scene of a restraint. Although the Monitoring Team's review of documentation during this site visit continued to cite a failure of nurses to respond in a timely manner, the implementation of this corrective action will be reviewed during the next visit. In another example, the Facility was attempting to address the question of adequate staffing ratios on the residential units through the development of a Corrective Action Plan. Although the discrete steps outlined in the CAP were reasonable, timelines had been extended without sufficient explanation. The Facility recognized the need to continue to strengthen its efforts. By 7/31/12, action plans included development of a standardized analysis format for sharing monitoring results. Corrective Action Plans were to include measurable objectives. By 3/31/12, required components of the Corrective Action Plans were to be identified, and by 4/30/12, approval was to be sought from the QA/QI Council. Corrective Action Plans continued to be 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. Seven CAPS were being tracked at the time of the site visit. In addition, nine workgroups had been established to address/improve recurrent systems. The CAP Tracking Log had been revised to include the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. The Monitoring Team noted in reviewing the CAP Tracking Log that timelines for the completion of certain CAPs were extended without a documented explanation for the delays. For example, the timeframe for the CAP focused on staffing ratios was extended by several months to 6/30/12, and the deadlines in the CAP regarding education about rights and the complaint procedure were each extended by one to two months. Potential barriers to the implementation of a CAP should be more clearly defined. The exploration of barriers might assist with the establishment of realistic timeframes. While this provision 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, progress continued to be made.	

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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 CAP Tracking Log had been revised to include the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. As documented by the meeting minutes and by observation at a QA/QI Council session held during the site visit, content and responsibilities for the completion of the Corrective Action Plans, as assigned, was discussed routinely at the QA/QI Council meetings. Documentation provided to the Monitoring Team included email correspondence delineating responsibility for these tasks. It was evident that the Director of Quality Assurance personally monitored the completion of these assignments. As a result, the Facility again 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.	The CAP Tracking Log documented the issue requiring remedial action, the date of dissemination, the responsible staff person, and the discrete actions to be performed by certain established timeframes. The protocol for monitoring the Corrective Action Plan was consistent with the intent of this provision. As discussed in the last report, corrective action plans need to be written to allow determinations to be made regarding their effectiveness. Without this determination, the Facility's leadership and the QA/QI Council cannot be assured that serious issues have been resolved. The Facility stated its intent to develop a process for the review of the effectiveness of a discrete Corrective Action Plan by May 2012. This initiative was reported to be underway at the time of the site visit. By 7/31/12, once the above action was completed, the QA/QI Council was to monitor Corrective Action Plans for measurable outcomes in order to determine their effectiveness at remedying the identified problems. The Facility's plans for compliance with this provision should be in full effect by the time of the next site visit. The Monitoring Team will continue to review progress towards compliance. It will be critical to determine whether the Corrective Action Plans result in demonstrable positive change for the individuals residing at LBSSLC.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	At its monthly meetings, the QA/QI Council reviewed Corrective Action Plans. The Facility stated its intent to develop a process by May 2012 for the review of the effectiveness of Corrective Action Plans. It is critical that the development and implementation of a strengthened process for addressing programmatic and environmental deficiencies continue to evolve. Upon review it was noted that the CAP Tracking Log had been revised to include the date of its	Noncompliance

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		inception as well as the person ultimately responsible for ensuring the completion of each assigned task. As noted above, the Monitoring Team noted in reviewing the CAP Tracking Log that timelines for the completion of certain CAPs were extended without a documented explanation for the delays. Further analysis of the barriers to completion should be completed, and the information used as other CAPs are developed. As noted above, the Facility should continue to 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.	

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)
7. Particularly when CAP deadlines are extended, potential barriers to the implementation of a CAP should be more clearly defined. The exploration of barriers might assist with the establishment of realistic timeframes. (Sections E.2 and E.5)
8. 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. (Sections E.4 and E.5)

9. 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)
10. The Facility's self-assessment should address not just the QA/QI Committee's responsibilities, but also the overall processes the Facility uses to accomplish the goal of a comprehensive quality assurance/improvement program (e.g., monitoring activities, development and implementation of outcome and process measures, ongoing activities with the various departments to analyze data, etc.). It will be particularly important to assess quality across the realm of initiatives, as well as the timeliness of them. (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: o **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 Self-Assessment, updated 2/29/12; o QA Minutes for monthly meeting regarding Section F, from 10/11 through 2/12; o In response to request that read: "Based on monitoring/audit data, or other reviews or data that the Facility has collected in relation to integrated protections, services, treatments, and supports, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed," the response: "None;" o Individual Support Plan Monitoring/Submission Tool, dated 3/27/12; o Memorandum regarding the Qualified Developmental Disabilities Professional (QDDP) Buddy System (Facilitator-Note Taker), dated 3/19/12; o LBSSLC Personal Support Plan Completion Tracking Tool; undated; o Annual Assessments Filed within 10 Days, meeting dates 9/1/11 to 3/1/12; o LBSSLC Home Address, Individual Support Plan (ISP) Dates, Dates ISPs Were Filed, and Previous ISP, undated; o ISPs held outside of the 365 days, undated; o ISPs that were filed more than 30 days after the annual ISP meeting, undated; o Blank monitoring form templates, including: ▪ 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 8/10; o Last 10 monitoring tools the QDDP Coordinator completed, various dates; o Last 10 monitoring tools the QA Department completed, various dates; o Supporting Visions: Personal Support Planning Workbook, dated 7/10; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool sample, dated 5/10/11; o Guide for Written ISP, dated September 2011; o List of QDDPs deemed competent using the "QMRP Facilitation Skills Performance Tool," undated; o QDDP Caseload Assignments, undated; o Individual Support Plans (ISPs), related assessments, Personal Focus Assessment (PFA), ISP signature sheet, Individual Support Plan Addenda (ISPAs), skill acquisition plans (SAPs), last three monthly reviews, last two quarterly reviews, daily schedule, and special considerations list for: Individual #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, Individual #199,

	Individual #94, Individual #111, Individual #116, Individual #125, Individual #174 and Individual #288; and o Draft ISP and Integrated Risk Rating form for Individual #51. o **Interviews with**: o Lola Walker, QDDP Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, QDDP Educator; and Jim Forbes, Director of Behavioral Services, on 3/20/12; and o Marilyn Foster, Program Compliance Monitor; and Dawn Ripley, QA Director, on 3/20/12. o **Observations of**: o ISP meetings for the following: Individual #51, Individual #98, and Individual #259; 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: Based on a review of the Facility's Self-Assessment with regard to Section F of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. Since the Monitoring Team's previous review, the Facility had made improvements in the justification it offered for its findings. Over a short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. On a positive note: ▪ The data the Facility had collected through its monitoring activities was beginning to show some of the issues that needed correction. ▪ Generally, some of the pieces of the methodology necessary to review this section were intact, such as observations of meeting, review of ISP documents, and review of monthly review documentation. The comprehensiveness and quality of the reviews continued to be a piece on which the Facility was working. The following concerns were noted: ▪ The data the Facility was collecting was not always comprehensive enough to show whether requirements of the Settlement Agreement were being met. For example, data collected with regard to the members of the team who attended ISP meetings was limited in scope, and not clearly connected to individuals' needs or preferences. As a result, it was not adequate to assist the Facility in determining compliance with the Settlement Agreement. ▪ The criteria used to evaluate components of the Settlement Agreement were often unclear. For example, for Section F.2.a.1, the Facility's data was vastly different from that of the Monitoring

	Team (as it was for many subsections) for indicators such as ISPs building upon individuals' strengths and preferences, or encouraging community participation. ▪ In addition, not all requirements of the Settlement Agreement had been reviewed. More specifically, within a subsection, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., F.1.e). If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed to add or revise the guidelines/instructions for the audit tools. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Overall, the Facility had demonstrated set forth a number of reasonable self-assessment activities, and had begun to use the data it collected to substantiate its findings related to compliance. Efforts to ensure the validity and reliability of the data will be important next steps, as well as using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section F is discussed in further detail below with regard to Section F.2.g.
	Summary of Monitor's Assessment: Since the last review, the Facility had taken additional positive steps to assist QDDPs in developing their meeting facilitation skills. These included: ▪ The QDDP Educator had worked with a number of staff throughout the Facility to develop an On-the-Job (OJT) training curriculum for QDDPs. Based on the information provided, it appeared that the training should assist in providing new QDDPs with a solid foundation with regard to the various disciplines, as well as the requirements for a QDDP. ▪ In addition, the QDDP Coordinator had set up a Facilitation Buddy Program. QDDPs were paired with one another, and each attended the other's meetings. The intent of this program was to provide QDDPs with weaker facilitation skills with the opportunity to observe meetings at which stronger facilitation occurred. In addition, by having another QDDP take notes, it was hoped that the notes from the meeting would improve, because QDDPs, as opposed to clerks, understood better what was relevant for the final ISP document. Based on the meetings observed while the Monitoring Team was onsite as well as review of ISP documents, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and, to a limited extent, a more person-centered focus. Some incremental positive changes were being seen in the ISP documents. For example, the Facility was clearly making efforts to broaden the scope of action plans included in individuals' ISPs, and to better define the roles of direct support professionals. However, as described in greater detail below, the Facility had much work left to do to ensure that ISPs set

	forth comprehensive plans with adequate indicators and measures to ensure that individuals received the protections, supports and services that they needed, and, most importantly that the efficacy of such supports and interventions were measured, and changes were made as necessary. Some areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition, vocational assessments, and physical and nutritional supports. Updated medical assessments often were not available at the time of the ISP meeting. Adequate assessments are the foundation for good individualized planning, and this foundation was not yet in place at LBSSLC. ▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen. ▪ Action plans had been broadened in scope. For example, the risk action plans had now been incorporated into the ISP document. However, these supports were not well defined, generally did not have measurable objectives or outcomes associated with them, and provided little description of the methodologies that would be employed to realize the objectives. Many other supports, services, treatments, or strategies were not addressed in the ISPs. For example, ISPs provided little definition of day and vocational supports, communication and other therapy supports, the full scope of nursing care plans, or medical and psychiatric treatment plans. Focused effort was needed to improve the scope of action plans, as well as to ensure measurable outcomes/objectives, and clear methodologies were included. ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc. ▪ Although it was positive that monthly reviews were now being completed and documented in the Integrated Progress Notes, they did not cover the full scope of ISP activities. 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, but this was not evident in the current monthly reviews. The QDDP reviews provided brief summaries of individuals' progress on their skill acquisition programs, and a summary of medical occurrences. To close the loop, however, the QDDP would need to review other team members' monthly reviews and take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	As noted in previous reports, the 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 quality assurance. Where it fell short was in describing how to design Action Plans, Skill Acquisition Plans, and Service Objectives so that they reflected the interdisciplinary coordination that is required. At the time of the review, it was the Monitoring Team's understanding that this policy and the related procedures were under review. LBSSLC had developed a number of policies related to the ISP process. According to documentation the Facility provided, since the Monitoring Team's last review, these policies had not changed. They included: 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; and o LBSSLC Policy "IDT Process Program Development: Active Treatment Program Development, Implementation and Monitoring," revised 6/28/11. Generally, these policies 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, Personal Focus Assessments, ISP signature sheets, Individual Support Plan Addenda (ISPAs), skill acquisition plans (SAPs), last three monthly reviews, last two quarterly reviews, daily schedule, and special considerations list. This sample included ISPs for 15 of the 220 individuals living at LBSSLC (7%), including Individual #237, Individual #84, Individual #107, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, Individual #199, Individual #94, Individual #111, Individual #116, Individual #125, Individual #174 and Individual #288. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and IDTs had been responsible for	

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		the development of the plans.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	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 ISP meeting. The LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, clearly identified the QDDP's role in coordinating and facilitating the team's activities. ▪ With regard to staffing, in addition to the QDDP Coordinator, since the last review, a QDDP Educator had begun working in this capacity after moving from another position on campus. The ISP Coordinator also continued to provide support to the QDDPs, but the person in this position was moving on to another job, and the position would then be posted and filled. 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 QDDPs. This generally allowed one QDDP to be assigned to each residence. The overall goal of maintaining a ratio of approximately 1:16 was being achieved, with a range of 1:11 to 1:19. There had been some turnover in QDDP staff, resulting in two new QDDPs. ▪ The QDDP Coordinator and QDDP Educator were certified trainers for the Q Construction Facilitating for Success training. 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. ▪ Since the last review, the Facility had taken additional positive steps to assist QDDPs in developing their meeting facilitation skills. These included: o The QDDP Educator had worked with a number of staff throughout the Facility to develop an On-the-Job (OJT) training curriculum for QDDPs. This involved a number of different meetings, observations, review and training on specific processes and requirements, and records reviews. It was conducted over a four-week period of time. For each week, a detailed schedule was developed. Based on the information provided, it appeared that the training should assist in providing new QDDPs with a solid foundation with regard to the various disciplines, as well as the requirements for a QDDP. Part of the process involved the new QDDP meeting with various staff, including many of the discipline heads. In addition to providing QDDPs with valuable information, this process also would allow them to become acquainted with many of the key staff	Noncompliance

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		on campus. A tracking log had been set up to ensure completion of each of the components of the training, and to identify any concerns that were noted during the process. o In addition, the QDDP Coordinator had set up a Facilitation Buddy Program. QDDPs were paired with one another, and each attended the other's meetings. When not primarily responsible for facilitating a meeting, the Facilitation Buddy took notes. The intent of this program was to provide QDDPs with weaker facilitation skills with the opportunity to observe meetings at which stronger facilitation occurred. In addition, by having another QDDP take notes, it was hoped that the notes from the meeting would improve, because QDDPs, as opposed to clerks, understood better what was relevant for the final ISP document. o In addition, a mock ISP had been developed to help guide QDDPs in the meetings, as well as in writing plans. Although this was a good effort, given the current work that State Office was completing with regard to the ISP, this likely will need to change to reflect State Office's expectations. ▪ During the week of the review, the Monitoring Team observed a number of team meetings. Progress definitely continued 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 ISP meetings, an agenda was clearly set forth, along with ground rules. o The QDDPs for all three ISPs the Monitoring Team observed did a good in preparing materials and packets. 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 to facilitate the meeting. 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 Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. o Clearly, efforts had been made to try to reduce the length of ISP annual meetings, while covering important content. Based on the meetings observed, QDDPs appeared to have come prepared, and the documents,	

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		such as draft Integrated Risk Rating Form and draft ISP format, appeared to provide team members with some relevant information and assist teams to remain focused. This will be a continuing challenge. However, it was positive that the Facility had focused on making better use of teams' time. 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 number of QDDPs. For QDDPs that they knew required additional training or technical assistance, they had not yet scheduled these assessments. Out of the 14 QDDPs, they had assessed seven current QDDPs as being competent in facilitation. However, based on interview, this process was assisting in identifying areas in which all of the QDDPs needed to improve their meeting facilitation skills. ▪ Based on review of ISPs as well as during observations of meetings held the week of the on-site review, missed opportunities continued to be noted with 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 Similarly, the individuals' strengths were not fully explored and/or used to as building blocks to address areas of need. 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	

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		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. Although some improvement was seen, problems continued 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 integration in ISPs 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. Regarding action plans related to high and medium risk ratings, overall the IDTs observed had limited and incomplete discussions of action plans related to these risk ratings. In several cases, the objectives were not functional and/or measurable, and adequate preventative measures were not discussed. 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 ISPs. As a result, IDTs did not establish a measure of success or failure of the action plan, and the interventions did not reflect the clinical intensity commensurate with the level of risk designated by the teams. o Teams continued to struggle with articulating meaningful outcomes for	

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		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). 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 well as professionals dictated by the individual's strengths, needs, and preferences. The Facility had identified an issue with regard to the completion of Personal Focus Assessments. As indicated in the State Office policy, this was the document that should have identified the team composition based on the individual's preferences, strengths, and needs. Based on documentation the Facility provided, between October 2011 and January 2012, a total of 86 PFAs had been scheduled, but only 24 (30%) had been completed. Based on interview with staff, in their investigation of this issue, they discovered that most of the meetings had been held, but the documentation had not been completed. This was problematic from a number of perspectives. Not only was the team composition not documented, but this also was the document on which team members were supposed to base their assessments. It was the document designed to provide a synopsis of individuals' preferences, strengths, needs, and desired outcomes. Without this summary, it would be difficult for team members to incorporate these essential factors into their assessments and recommendations. PFAs that had been completed often did not define the team members that needed to be present at the annual ISP meeting. It remained 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. Based on the Facility's Action Plan for this section, it appeared that the Facility had developed some attendance protocols, and was beginning to work with teams and discipline heads on their use. Additional	Noncompliance

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		concerns with regard to the timeliness and quality of the PFAs are discussed with regard to Section S.2 of the Settlement Agreement. The Facility had been tracking attendance at annual 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. The data the Facility provided was limited, because it only included certain team members and not others. For example, data was not provided regarding attendance of Habilitation Therapies, Psychiatry, or Dental Department staff. However, based on the data, problems were noted with regard to the attendance of direct support professionals, Legally Authorized Representatives, and for the month of November, individuals. The Facility recognized the need to have direct support professionals present at the meeting. The Director of Residential Services reportedly was working on better scheduling to allow this to happen. Based on the sample of 15 ISPs the Monitoring Team reviewed, for three (20%) it appeared that a duly constituted team was in attendance (i.e., Individual #125, Individual #199, and Individual #107). As the Monitoring Team reviews individuals' ISPs, as well as the related assessments, if needs are identified for which the presence of a team member was warranted, but the requisite team member was not in attendance and no justification was provided, then the conclusion is drawn that a duly constituted team was not present. In the ISPs reviewed, 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 the Facility was continuing to populate its ISP attendance database, had an action plan to begin to address the identification of team members that needed to be present at ISP meetings, and was beginning to identify issues with attendance, 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. ▪ As noted in the Monitoring Team's last report, a database had been initiated to track assessments. At that time, there were issues with the database. However,	Noncompliance

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		since then, it had been populated with data. The reports that the Facility provided showed data regarding the timeliness of assessments on a residential unit basis, an individual basis (i.e., cumulative percentage), by ISP meeting date (i.e., per assessment), and by type of assessment. As the Facility staff reported, some of the data was difficult to interpret. This was due to the criterion used to measure timeliness. It required all assessments to be completed 10 days prior to the ISP meeting, but some assessments were completed at the ISP meeting (e.g., the Health Risk Assessment). However, the development and implementation of this database should be helpful in identifying areas in which team members are doing well, and those requiring attention. ▪ The Facility recognized that the quality of PFAs was problematic. To address this, the QDDP Educator had begun to review PFAs, and return them to the QDDP if issues were identified. In order to provide some level of technical assistance, when PFAs were returned for corrections, the QDDP Educator provided examples of best practices. ▪ In an effort to ensure assessment documentation was available in a timely manner, the Facility continued to use the folders that 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). However, at the time of the review, little improvement was noted with regard to the timeliness, quality, or the completeness of the assessments used in developing ISPs. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, the Facility had populated the assessment database. Based on the data provided for the period between 9/1/11 and 3/1/12, a number of types of assessments were submitted to the teams at least 10 days prior to the ISP meetings less than 70% of the time. These included, for example, vocational, Self-Administration of Medication (SAMS), psychological, nursing, medical, and dental assessments/evaluations. ▪ Based on a review of 15 individuals' ISPs, for none of the individuals (0%) did it appear that all the various types of assessments necessary to address the individuals' strengths, needs, and preferences were available at the time of the ISP meeting. It should be noted that, at times, it was difficult to determine if the assessments included in the packages the Facility provided to the Monitoring Team were those available to the IDT at the time of the ISP. In a number of cases, the date on the assessment made it appear that the assessment was completed prior to the ISP meeting, but the date stamped at the bottom indicating when the assessment was filed was significantly later than the ISP	

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		meeting date. However, even when making the assumption that some of these might have been available electronically, all individuals in the sample had at least one assessment that appeared to be missing or significantly late, including PFAs, medical assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessments, psychiatry assessments, OT/PT assessments, dental summaries, Functional Skills Assessments (FSAs), etc. Although the Facility was implementing the use of the PFA, as noted above, the Facility recognized that these were not consistently being written up, and even when they were, most did not identify which assessments should have been completed. 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. ▪ For none of the individuals (0%), the quality of the assessments was adequate, including clear identification of the individuals' strengths, needs, and preferences. With most assessments, this information was integrated throughout the report, but no analysis or listing of the information was provided. Individuals' strengths generally were not referenced in the recommendations included in assessments as assets through which individuals' needs or preferences could be addressed or met. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. 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 details 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' ISPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. ▪ Assessments also frequently did not include adequate recommendations. Some of the issues noted included: o Some assessments typically included no or limited specific recommendations (e.g., nursing, the Functional Skills Assessments, and dental).	

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		○ Recommendations frequently were not oriented to the development of action plans. For example, a recommendation that read: "will continue to work in vocational services" was not sufficient to describe what supports the individual needed. In this case, the team needed more information about what was working in vocational services, what was not, what additional training or support the individual needed to become more independent or move into more integrated work, what preferences the assessor had identified on which the team could capitalize, etc. ▪ 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, as well as the supports needed. If not, the assessor needed to identify the reasons. Based on the review of sample plans, this was not occurring consistently, but was seen in a number of assessments. For example, one of the assessments that did not appear to routinely include this information was the psychiatric assessment. In a number of other assessments reviewed, a statement was made regarding the professional opinion of the assessor with regard to the individual's appropriateness for transition. However, the information regarding supports needed was missing or limited. ▪ In previous reports, the Monitoring Team suggested that one assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. Based on a review of the newer ISPs, this had become a standard discussion topic for teams. However, at this point, teams' discussion was limited. This seemed due, in part, to team members not having full access to information related to investigations of abuse and neglect. Although it is understood that the team cannot see the entire report, consideration should be given to providing teams with a summary of information that would help them to ensure that they developed adequate plans to prevent abuse or neglect in the future. In addition, what was sometimes missing was a real critical review/analysis and integrated discussion to come up with solutions to the patterns or trends identified. For example, Individual #184 experienced a number of falls, some of them resulting in serious injury. However, the assessment of the potential causes was not completed in an interdisciplinary manner, and as a result, no meaningful action plans were developed to address the pattern. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate ISPs. This is an area that will require the concerted efforts of all team members to bring the Facility into substantial compliance.	

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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 15 plans (0%) were all recommendations resulting from assessments addressed in the ISPs 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. The revised ISP template included a section that read: "Review Any Assessment Recommendations not already addressed in the ISP." A chart followed this header with the following columns: Assessment/Date, Recommendation, and Deliberations/Actions. Under the Deliberations/Actions header, teams were asked to document their deliberations. Then, if the recommendation was to be implemented, they were to write an action plan, but if it was not to be implemented, the team was to write its rationale. Although teams had filled this in, two problems were noted. One was that these lists generally did not include all of the recommendations that not had been otherwise addressed. The second was that even when the team indicated it had accepted a recommendation, often no corresponding action plan or objective was found. ▪ Although less of this was seen, at times, 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 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.	Noncompliance

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		As has been recommended in the past, 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 ISPs, 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).	Based on information the Facility provided, the following activities had occurred to provide additional education to QDDPs regarding community living options: ▪ On 10/28/11, the QDDPs and QDDP Coordinator had attended Community of Services Living Options Training that the Local Authority provided. It included information about the Community Living Options Information Process (CLOIP), the referral process, as well as information about various options in the community. It was positive that the QDDPs had participated in this training. ▪ On 1/20/12, all QDDPs were required to attend a meeting at which the Most Integrated Setting was the topic. The Admissions Placement Coordinator provided more in-depth information on topics such as the obstacles database, the Review of Placement Appeals process, Community Exposure Tours, Living Options Discussions, referrals, the upcoming Provider Fair, and assessments. This also appeared to be helpful information for the QDDPs. ▪ On 2/17/12, the QDDP meeting included a review of the revised Continuity of Services Policies on Admissions, Community Placements, Discharges, and Final Summaries. In addition, due to concerns that the State Office reviews had identified with regard to teams' Living Options discussions, additional training was in the planning stages. The QDDP Coordinator indicated that a training session on this topic would be done in conjunction with other training and recognition activities. In addition, the QDDP Coordinator and QDDP Educator had begun to review Living Option discussions, and provide feedback to QDDPs and teams. 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. A subset of nine plans were reviewed including those for: Individual #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, and Individual #199. To highlight some of the issues of concern: ▪ Teams were not consistently providing independent assessments of individuals' ability to transition to a more integrated setting. In order for the State Office	Noncompliance

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		requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o As noted above in the discussion regarding the quality of the assessments, some assessments included the required statements/recommendation, and others did not. o Of the nine ISPs reviewed, one individual (i.e., Individual #107) had been referred for transition to the community a few months previously, so this was not reviewed again. For the remaining eight individuals, team disagreements were noted in either the ISP document or the assessments for six individuals (75%) (i.e., Individual #237, Individual #160 per the assessments, Individual #318, Individual #23, Individual #29, and Individual #199 per assessments). Of these, one individual (i.e., Individual #237) was referred, and it was not clear how the team disagreement about this had been resolved. It was not clear for any of these individuals that the professionals on the team offered one joint recommendation to the individual and guardian. For two individuals (25%) (i.e., Individual #84, and Individual #184), the teams were polled and all team members agreed the individuals could be served in a less restrictive settings. However, it was unclear that this was made as a joint recommendation of the team to the individual and guardian. Rather, the teams indicated that the LAR objected, and, the team agreed the individual should not be referred for transition. ▪ 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 making progress in this regard, but work was still needed to ensure teams were familiar with and using the State Office categories for obstacles.	
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		

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	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 Plans 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." Section F.2.a relates to the development of adequate action plans. As is illustrated below, the Facility was making concerted efforts to try to improve the action plans included in ISPs. Some of these efforts were resulting in positive changes. However, as noted below, much work was needed for the Facility to meet the requirements of the Settlement Agreement. One of the efforts had been the development of draft Action Plan Development Instructions, dated 2/20/12. Although this document included some helpful information, it did not comprehensively outline solutions to the ongoing problems with action plans. Facility staff should continue to work with State Office staff and consultants to develop training methodologies and resource materials for QDDPs to assist them as they guide teams through the action plan development process. 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 15 of the ISPs reviewed included a listing of individuals' preferences, two (13%) had effectively incorporated her preferences into related action plans (i.e., Individual #84, for whom the QDDP was going to try to find a book club for him to join due to an interest in reading; Individual #184 had an interest in writing, and an action plans was developed for her to buy a writing desk. She also liked magazines, so an action plan to help her chose a magazine subscription was developed). For the remaining individuals, none of their 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. Even for Individual #184, the team had not looked at building on these preferences to	Noncompliance

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		expand her horizons off campus, such as visiting the library to pick out magazines. ▪ 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.). More specifically, in none of the 10 PSPs reviewed (0%) were priorities clearly defined, or barriers identified and addressed. In Individual #107's plan, the team provided some insight into how skill acquisition goals were selected over others. Although this was not a comprehensive prioritization of the individuals needs, it was positive to see that the team had thought this through. In addition, although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams often cited individuals' behaviors or attitudes as preventing them from participating in activities (e.g., work), but teams had not clearly defined such issues as barriers, and/or implemented plans to address them. More specifically, in one of the 15 ISPs reviewed (7%) (i.e., Individual #199's team identified the feeding pump as a barrier to more off-home activities, so alternative were being researched) were barriers identified and addressed. <u>Identification of Supports Needed to Encourage Community Integration</u> In reviewing objectives related to individuals' involvement in the community, they continued to be extremely limited. One of the 15 ISPs (7%) (i.e., Individual #23) reviewed included specific skill acquisition action plans for implementation in the community. Some individuals had "community" checked as the place in which the action plan would be implemented. However, often these were overall supports that needed to be provided wherever the individual was (e.g., implementation of BSP). In other cases, no specific requirements were included for the community being the venue for the objective's implementation, because it was listed as one of many (e.g., making a purchase). This is discussed in further detail with regard to Section S.3.b.	

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		Two of the 15 individuals (13%) (i.e., Individual #199 and Individual #84) included objectives to encourage their participation in community activities. For these two individuals, teams had tried to tailor the community involvement to meet the individuals' specific interests (e.g., preference for eating out, going to church in the community, and participating in a book club) or needs (e.g., family wanted to take him out to the park, but needed staff assistance). For many individuals, though, the related objectives were general (e.g., "participate in ongoing activities on and off campus), or called for such infrequent community involvement (e.g., twice a month) that this could not be construed as "encouraging community involvement." 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. This was an area in which the Facility clearly had made an effort to improve. Action plans related to individuals' risks had been incorporated into the ISP document itself, and teams were making efforts to include more of the individuals' protections, supports, and services in the action plans. ▪ However, none of the 15 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 and habilitation, the supports they were provided, and the teams' ability to measure progress, or lack thereof. More specifically: o 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. o Similarly, objectives such as "will be provided the opportunity to work on a variety of contracts" did not adequately define the training or	Noncompliance

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		habilitation that would be provided, nor did it define a measurable support that staff would provide to the individual. Particularly, when such an objective was the only objective describing, for example, day/vocational supports for an individual, the ISP failed to adequately describe the individual's supports and services or offer an appropriate habilitation program. They also provided the team with no way of measuring success or failure. o 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. For example, none of the plans reviewed for individuals with psychiatric treatment plans identified the target behaviors that would be measured to provide adequate feedback to the psychiatrist regarding the efficacy of medications. Although PBSPs sometimes were identified in action plans, frequently, the only reference was that direct support professionals needed to implement them. Objectives to measure the individual's progress with regard to target or replacement behaviors generally were not included. Similarly, service/support objectives were included indicating that PNMPs or communication supports would be provided. However, measurable objectives related to these supports generally were absent. ▪ In reviewing the action plans that had been developed to address individuals' risk areas, adequate measurable clinical indicators generally were not included. This is discussed in further detail with regard to Section I of the Settlement Agreement. However, the lack of these clinical indicators resulted in teams not having a mechanism to measure whether the person was progressing, declining, or remaining stable. For example, objectives that read: "the individual's "blood pressure is monitored each morning (seven days a week) by the nurse administering his medication" or "The Behavior Analyst will track [Individual's] behavior by review of data cards weekly and prepare Progress notes..." were helpful in that they provided a description of the supports staff needed to provide. However, without corresponding clinical indicators (e.g., goal for blood pressure or parameters for notification of PCP) or outcome measures (e.g., objective for reduction in target behavior or increase in replacement behavior), the individuals' health status and/or behavioral status could not be measured. In addition, without parameters regarding when the nurse needed to contact the PCP, or the team needed to meet, changes in status were likely not being adequately addressed. ▪ As is discussed elsewhere in this report, deficits in plans that specific disciplines	

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		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. ▪ Individualization of goals also appeared to be problematic in some cases. For example, in reviewing this sample of ISPs, numerous individuals had objectives related to: 1) making cards and sending them to family members; and 2) participating in self-advocacy meetings. In limited cases did this appear to be a clear choice of the individual, and/or relate to a specific recommendation in an assessment. As creative ideas for programming are identified (e.g., making and sending cards), care should be taken to ensure that this does not become the fallback objective for many individuals regardless of their interest or other activities that would be more appropriate. Similarly, although all individuals should be given the choice to participate in self-advocacy activities, it should not be written into every 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 15 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 medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care/health management plans 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. As noted above, although it was positive that PBSPs and PNMPs were mentioned in ISPs as needing to be implemented, measurable objectives generally were not included. ▪ Action plans often did not recognize the multiple staff and disciplines that needed to be involved in the training of staff, implementation of the programs/plans, monitoring of the implementation, and updating/maintenance	Noncompliance

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		of the plans and/or related equipment. On a positive note, direct support staff's role in implementing plans was mentioned more frequently in action plans. However, their role was only one of many that ISPs needed to define. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. The roles and responsibilities of clinical staff in the training of staff, monitoring of programs, and review and revision of programs was generally missing. ▪ 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 or psychological supports were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, rapid eating pace, 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.	
	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. Improvements were seen in the ISPs reviewed regarding more specific timeframes. In the Monitoring Team's previous reports, it was noted that often, timeframes were weak, referencing, for example, "as requested," or "as available," or "ongoing." Although teams continued to use these terms on occasion, more specific timeframes generally were included in the action plans. However, as noted with regard to Section I, teams will continue to need to be vigilant, because some timeframes will require more specification than even "weekly" or "daily." For example, when defining monitoring of certain health care conditions, the shifts or specific times that such monitoring needs to occur might need to be defined. This will require significant individualization of the timeframes. For example, plans included objectives such as: ""IDT will formally monitor staff to ensure PNMP is being followed." The persons responsible were the "IDT," and the timeframe was "7 days a week." In essence, this made everyone responsible, but, at the same time, no one responsible. It was unclear if this meant spot checks would be completed, how many would be done weekly, and what "formal" monitoring tool would be used. In addition, methods for implementation were not always adequate or present. In other words, the "how" was not provided. In none of the 15 plans reviewed (0%) was the methodology sufficiently described for the action plans included. For example, action steps that read: "encourage to loose weight and exercise," "DSP [direct support professional] will encourage fluids and activity," or "DDP will monitor for any signs or symptoms of cardiac concerns" did not provide a methodology for accomplishing the	Noncompliance

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		implementation phase. In addition, as is discussed with regard to Section I, action plans for individuals identified 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. As noted above, based on the plans reviewed, the Facility had made a concerted effort to include the roles of direct support professionals more prominently in action plans. This will be an area that will require continued focus. A major issue that impacted the adequate definition of these roles is discussed in the paragraphs above. Without a clear methodology for many objectives, it remained unclear specifically what direct support professionals' roles were. As also noted above, the roles and responsibilities of clinical staff in the training of staff, monitoring and updating of programs, and review and revision of programs was generally missing. Without this information, ISPs contained an incomplete list of the supports and services individuals required.	
	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 15 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, communication 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. None of the individuals' plans reviewed included a cooking goal. Similarly, individuals generally did not have objective related to housekeeping or yard work, which would be typical activities for independent adults. 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	Noncompliance

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		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 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. In some cases, it already had become an issue. For example, Individual #84 was used to wandering around campus, and one of his guardians concerns about community transition was that he would not be safe in the community with such a routine.	
	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, ISPs and the resulting skill acquisition programs contained some 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 those related to PBSPs, individuals' ISPs did not consistently identify the specific data to be collected, the frequency, and/or the persons responsible for such data collection. With the 15 plans reviewed, this was a significant deficit. Overall, the plans defined very little objective data that would be collected, reviewed, and used to make decisions regarding the efficacy of plans. In addition, the ISPs generally did not identify the person responsible for data review. Often, it was assumed that these would be two different people. Even in the limited cases in which data collection requirements were defined and a person(s) responsible for collecting data were identified, the staff responsible for reviewing the data were not identified. 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 15 ISPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Although teams were reviewing more data in relation to the risk ratings, this was not then translated into	Noncompliance

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		measurable objectives or clinical indicators to allow ongoing review of the individuals' status. In addition, although teams were now reviewing the previous year's skill acquisition programs to determine if they should be continued or not, little data was cited to justify the teams' decisions. 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. However, there were some indications that the data being collected was not reliable.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the Monitoring Team's previous reviews, and based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.II.D.m required the 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 15 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. As noted above, often, the methodology, or the "how" was missing. While the Monitoring Team was onsite, the Facility presented a new initiative that it was undertaking to develop a "Reference Guide" for direct support professionals. Although	Noncompliance

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		this initiative had just begun, it appeared that it would provide a helpful tool to direct support professionals. It summarized an individual's risk ratings, and the key pieces of the action plan for which direct support professionals were responsible. In addition, brief synopses of individuals' PNMPs, skill acquisition plans, and goals/objectives were provided. Other plans were referenced as necessary. This would appear to be a positive addition to the references provided to staff. 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.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III addressed personal support plan monitoring including the requirements of the Settlement Agreement. The LBSSLC Policy "IDT Process Program Development: QMRP Role in Coordinating Active Treatment Programs," dated 3/15/11, delineated the QMRPs' role in monitoring the 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 written reports." As indicated in the Monitoring Team's last report, 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 ISPs. As noted above, one practical issue that remained was that ISPs did not consistently clearly define these parameters. For the sample of 15 individuals, the last three months of monthly reviews were requested. For seven of these individuals (47%), three monthly reviews were available. 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." However, based on interview with staff, a mechanism had been developed to provide data in the quarterly reviews for the skill acquisition plans. The process developed would automate the generation of graphs to assist in the summary of relevant data. This should be a very positive addition to this process. In addition, the reviews were limited to review of skill acquisition programs, the	Noncompliance

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		presence of certain documentation in the records (e.g., ISP, medical assessment, skill acquisition plans, etc.), a summary of medical issues or appointments, and review of the individual's clothing inventory. This did not represent a full review of each program or support. In part, this was due to the fact that for many plans, such as PNMPs, nursing care plans, psychiatric medication plans, and PBSPs, objective measures had not been defined in ISPs. As a result, it remained unclear how an individual's progress or lack thereof would be measured. In the current monthly review, 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. At the time of the review, the Facility was working on a new template to assist with this process. As noted above, data would be added for skill acquisition programs. Although the template appeared to cover a number of other relevant areas, it was not clear how the specific requirement that: "the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed." The Facility is encouraged to work with State Office staff and consultants as it develops its processes for meeting this requirement. 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. For example, numerous examples of this are provided with regard to nursing care.	
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	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 QDDPs 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 ISPs 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	Noncompliance

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	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.	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. At the time of the review, seven current QDDPs had been deemed competent. 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. ▪ Of significant note was the development of an On-the-Job training scheme for new QDDPs. This was a positive addition, and is discussed in detail with regard to Section F.1.a. As also discussed in that section, another positive addition was the Facilitation Buddies program that was designed to offer peer technical assistance during ISP meetings. ▪ As noted with regard to Section F.1.e, additional education had been provided to QDDPs regarding community living options, and more was planned. The full list is provided above. ▪ The QDDP Coordinator, as well as members of the ISP Workgroup, continued to sit in on team meetings and provide technical assistance in real time. In addition, the QDDP Educator and QDDP Coordinator were reviewing samples of ISPs and PFAs, and providing ongoing feedback. These efforts should continue, because they likely will have the greatest impact on improving the process. ▪ As noted previously, based on a limited number of observations of ISP meetings while onsite, improvements continued to be seen with regard to the team process. 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 seven 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	

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		area. In an effort to ensure inter-rater reliability, the QDDP Coordinator and/or the QDDP Educator were observing some of 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: ▪ The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified. ▪ Evidence should be related directly to the indicator, and guidelines should be provided as necessary to support reviewers' understanding of the indicators. ▪ Two areas of quality that the checklist 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. ▪ 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 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	

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		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 shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on documentation the Facility provided, seven individuals' annual ISP meetings were not completed within 365 days of the previous meeting. Although this information did not indicate the total number of ISPs referenced, at the time of the review, the census was 220 individuals. Based on this number, the rate of timely completion of annual ISP meetings was approximately 97%. According to this documentation, requests were obtained from the Facility Director to extend the 365-day deadline. These extensions were sometimes due to individuals being hospitalized, or requests from families to be present at individuals' meetings. The Facility was tracking the completion and filing of ISPs. According to documentation the Facility provided, 203 ISPs were filed more than 30 days after the annual ISP meeting. Although this information did not indicate the total number of ISPs referenced, at the time of the review, the census was 220 individuals. Based on this number, the rate of timely file of annual ISP meetings was 17 ISPs (8%). 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 ISPs 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.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the	Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs 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 ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ Since the last review, the Program Compliance Monitor and QDDP Coordinator had met, and decided to modify the way monitoring was completed. The QDDPs	Noncompliance

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	provisions of this section.	all used to be involved in the completion of audits of a sample of ISPs. Since the 1/10/12 meeting, only the QDDP Coordinator and Program Compliance Monitor were conducting monitoring. The goal was to try to achieve better inter-rater reliability. ▪ Another important and positive outcome of the meeting was the decision to create a set of instructions to define the implementation of the monitoring tools. The goal was to have the instructions completed by August 2012. ▪ A positive modification also had been made to the sampling technique used. Specifically, for each month, the sample of records was pulled based on ISP meetings that had been held 60 days previously. This allowed time for the ISP document to be completed and filed. The Program Compliance Monitor was attending/auditing the ISP meeting, as well as the resulting ISP document. This provided the Program Compliance Monitor the opportunity to ensure that important information discussed during the ISP meeting was captured in the ISP document. ▪ As was discussed in the Monitoring Team's previous report, the QDDP Coordinator and Program Compliance Monitor had been meeting monthly to discuss the results of the reviews. This was positive. However, based on review of the minutes, the discussion at these meetings was limited. This is discussed in further detail below. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ For the various monitoring/audit tools, inter-rater reliability still 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 above, Facility had begun to take steps, such as the identification of staff with subject-matter expertise to conduct monitoring, ongoing communication between these staff, and development of instructions to improve both the reliability and validity of the data. ▪ As discussed in previous reports, the guidelines/instructions for the audit tools required modification. As noted above, plans to develop/improve such guidelines/instructions were underway. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). Instructions also should clearly direct auditors to review the quality of the ISPs, assessments, objectives, etc., and not just their presence or absences. ▪ 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	

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		have captured relevant issues with ISPs. Although some of the tools from more recent months showed varying compliance rates, 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 was not surprising. ▪ The Facility's analysis of the data continued to be at the beginning stages. As noted above, the QDDP Coordinator and Program Compliance Monitor met monthly to review data. However, minutes from these meetings showed emphasis on the timely filing of ISPs, as opposed to qualitative aspects of the process or ISP documents. 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. However, the data reviewed appeared quite limited. This group made decisions about the need for formal corrective action plans to be developed and implemented. Based on documentation and interview, no corrective action plans currently were being implemented with regard to the ISP process or documents. One had been in place, but was discontinued. Although it was positive that steps were being taken to improve the data, until valid and reliable data are available, the QA/QI Committee will be limited in its review and action plan development. In the meantime, based on available data, as well as information the Monitoring Team provides in its reports, the Facility should continue and enhance its efforts to improve the quality of both the ISP process and resulting documents. In its Self-Assessment, 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 improve and 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 it 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. Although it is understood that the team cannot see entire investigation reports, if not already available, consideration should be given to providing teams with a summary of information that would help them to ensure that they develop adequate plans to prevent abuse or neglect in the future. (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. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
8. 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)
9. 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)
10. 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)
11. 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. The roles of all clinical staff also should be defined. 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)
12. As teams continue to receive training on the new ISP 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)
13. 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)
14. 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)
15. ISPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
16. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that ISPs 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, including the methodology, or the "how" for objectives. (Section F.2.c)

17. 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 ISPs. (Section F.2.d)
18. QDDPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate ISP 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)
19. 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 of quality that the checklist 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)
20. 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)
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 and Facility Self-Assessment)
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)

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: o **Review of Following Documents**: o For one individual from each residence for the past month, all consultant reports (medicine and surgery inclusive of subspecialties) and all integrated progress notes commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing), and any ISP addendum related to the consultant report for: Individual #258 Neurology, dated 1/25/112, and Urology, dated 2/17/12; Individual #183 ophthalmology, dated 11/10/11, Neurology, dated 1/25/12, Endocrinology, dated 3/1/12, and Podiatry, dated 1/25/12; Individual #6 Urology, dated 12/14/11, Surgery, dated 1/30/12, Urology, dated 2/10/12, and Surgery, dated 2/16/12; Individual #209 Endocrinology, dated 10/27/11, and ENT, dated 2/16/12; Individual #43 Orthopedics, dated 12/30/11, Orthopedics, dated 2/10/12, and Ophthalmology, dated 2/3/12; Individual #233 Cardiology, dated 1/10/12, Internal medicine, dated 1/26/12, Radiology, dated 2/1/12, Cardiology, dated 1/24/12, Radiology, dated 1/25/12, Neurology, dated 12/9/11, Internal medicine, dated 2/7/12; Individual #309 Allergy, dated 12/21/11, Internal medicine, dated 12/14/11, Neurology, dated 10/5/11, and Pulmonology, dated 2/17/12; Individual #291 Ophthalmology, dated 12/1/11, and Cardiology, dated 2/23/12; Individual #45 Radiology/Imaging, dated 10/7/11, Urology, dated 1/18/12, Urology, dated 2/8/12; Individual #131, dated Podiatry 2/8/12, and Podiatry, dated 2/14/12; Individual #124 Neurology, dated 10/14/11, Podiatry, dated 11/16/11, Podiatry, dated 12/21/11, Podiatry, dated 2/6/12, Neurology, dated 1/27/12, and Podiatry, dated 1/25/12; Individual #298 Radiology/Imaging, dated 2/16/12, and Vision, dated 2/24/12; Individual #25 Ophthalmology, dated 12/2/11, Neurology, dated 12/9/11, Ophthalmology, dated 2/27/12, and Ophthalmology, dated 2/29/12; Individual #130 Pulmonology, dated 2/16/12; and Individual #51 Neurology, dated 2/8/12; o Most recent Physical and Nutritional Management Team (PNMT) recommendations with physician orders; and o Presentation Book for Section G. o **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Melody Morton, RN, Clinic Manager.
	Facility Self-Assessment: The Facility determined in its self-assessment that it remained out of compliance with Section G. This was consistent with the Monitoring Team's findings. Although the overall format for the self-assessment was improved, and the Facility had engaged in some meaningful assessment activities, a number of concerns were noted with regard to the assessment the Facility had conducted to reach its conclusions. Based on the Facility's self-assessment, the Medical Department had identified ways to measure

	compliance with the integration of clinical services through the morning medical meeting, tracking of hospital and ER visits, implementation of PNMT recommendations, as well as through the external peer review process. Although, as discussed in further detail below, this was not a complete list of areas in which integrated clinical services should be measured, it represented a good start. Based on the Facility's Self-Assessment, the Medical Department had conducted a number of reviews, but as noted below, data was lacking in a number of areas: ▪ In its self-assessment, the Facility stated: "When reviewing the data from the medical provider quality assurance audits, the November 2011 external provider audit showed a 98.8% completion rate." However, it was unclear what this meant in terms of Section G.1 of the Settlement Agreement. Providing an overall score such as this did not assist the Facility in identifying whether or not it was in compliance with the requirement for integrated clinical services, and, if not, what specific concerns it needed to address. If specific indicators within these reviews addressed this Settlement Agreement requirement, then the data should have been isolated and analyzed. ▪ Closure items were documented through the morning provider meeting minutes. A worksheet for data entry of the information provided an efficient format. However, no data was provided to reflect the progress and goals of the morning medical meeting (e.g., how many of the concerns needing closure remained outstanding at any point in time, how many concerns addressed steps to be taken to prevent a repeat hospitalization or emergency room visits for an individual discussed at the morning provider meeting, what was the length of time between the committee identifying the concern and documentation of closure for that concern, how many concerns were identified per month, and a breakdown of categorization of types of concerns. for tracking the concerns needing closure). The Facility Self-Assessment also included no information about the impact of the concerns raised in the morning provider meeting on the ISPA process, or feedback that the IDTs provided to the committee regarding decisions made based on the recommendations made in the morning meeting. ▪ Attendance was tracked at the morning provider meeting, with six departments routinely attending. However, no data was provided regarding the percentage of meetings each department attended, nor was any other data collected to reflect the quality of the participation from the attendees. ▪ There was no data to reflect follow-up PCP orders for PNMT recommendations. For Section G.1, the Facility included the following in the self-rating section: "Based on this self-assessment, this provision is not in substantial compliance as improved tracking of ER and Hospital visits is needed to ensure integration of needed services." As noted above, the Facility's analysis of its compliance with Section G.1 was inadequate. As a result, although the overall self-rating of noncompliance was accurate, the summary was not an adequate reflection of the issues that remained to be addressed. The Facility identified several databases it planned to develop, but these were not in place at the time of the Monitoring Team's visit. For Section G.2, this included tracking of consultation reports to determine the primary care providers" (PCPs') review and follow-up, tracking to determine whether all consult recommendations were reviewed within five business days, and monitoring data to assess staff's

	knowledge of the risk plans. In addition, for Section G.2, the Facility referenced the February 2012 external audit. However, again, an overall score was provided. This was not helpful to the Facility in determining its compliance with this specific requirement of the Settlement Agreement. In addition, the information that the Facility included in this section of the Self-Assessment focused on the role of the Medical Department, which was pivotal. However, all clinical departments are essential in providing integrated clinical care, and each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus. The role of the IDT is essential, and measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. In the current self-assessment, the Facility had focused on recording attendance of various departments at the morning provider meeting. However, there is considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the Integrated Risk Discussion Results, the Risk action plans, the implementation steps taken, and the outcomes. This could be tracked for stable conditions as well as changes in health status. At the time of the Monitoring Team's visit, no data was available to measure many of these components that demonstrate integrated clinical care.
	Summary of Monitor's Assessment: Although the Facility was not in compliance with either of the subsections of Section G, progress had continued. Although improvements were still needed, some level of integrated care took place through a variety of committees that were the forums for interdisciplinary discussion, including the Medication Safety and Systems Committee, the morning provider meeting, the Physical and Nutritional Management Team, and the IDTs. The morning provider meeting provided an integrated approach to clinical care on campus. During this meeting, nurses attending the meetings later communicated concerns to the QDDP. Reportedly, if needed, the QDDP would call an IDT meeting to address the concern, and if necessary, held an ISPA addendum meeting. If there were a health status change, the ISPA was supposed to reflect action steps and a change in risk rating. The nurse from the PNMT also attended the morning provider meeting. The morning provider meeting included a review of hospitalized individuals by the Hospital Liaison Nurse. Community consultant reports also were read at this committee, and reportedly, this information was subsequently discussed at IDT meetings. However, based on the Monitoring Team's review of related documentation, teams were not reviewing consultant reports and related PCP recommendations, and/or documenting this discussion and the teams' decisions. Significant improvement was needed in documentation of the IDT review of consult reports and follow-up. Although improvements were seen in the morning medical meeting, all clinical departments are essential in providing integrated clinical care. The Facility had begun to identify data it was collecting, but it had not developed a set of measurable indicators for each department that reflected the integration of care across the campus. For example, measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. Similarly, there is

	considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the integrated risk discussion results, the risk action plans, the implementation steps taken, and the outcomes. However, the Facility had not yet begun to define these indicators.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The morning provider meeting was an important forum for the integration of clinical services. At the time of the Monitoring Team's onsite review, the team member completing the minutes tracked attendance using a check-off list. However, an attendance roster participants signed, and then maintained on file would ensure accuracy of the roster listed in the meeting minutes. The Medical Compliance Nurse would be able to monitor attendance using this signed roster and check the signature roster against the meeting minutes roster. The Facility's Self–Assessment indicated that no current information management system was in place to track the various departments' attendance at the morning provider meeting, but this was identified as a goal. As a measure of integrated care and integrated discussion, following through on this goal to track departmental representation at the morning provider meetings is recommended. Attendance at the time of the Monitoring Team's onsite visit consistently included the Medical Director, all PCPs, Staff Psychiatrist, Staff Dentist, representation from pharmacy, nursing administration, the Hospital Liaison Nurse, the Infection Control Nurse, the PNMT Nurse, several RN Nurse Managers, and a member of the QA/QI Department, As part of the integrated clinical process, the morning provider meeting included reports from a variety of clinical disciplines. A member of the PNMT reported weekly on recommendations made during their consultations and ongoing monitoring visits. This provided the background information and updates needed for follow-through by nursing staff and the PCP. In order to verify the integration of the PNMT recommendations into the IDT process and determine if these recommendations were implemented, a sample of 10 recent PNMT recommendations with PCP orders was requested. PCP orders were considered a measurement of implementation. In response to this request, LBSSLC submitted PNMT assessments/follow-ups/updates for nine individuals. Two individuals had two follow-up documents submitted. Of these11 sets of follow-up documentation, there were eight accompanying physician orders to verify that the recommendations had been implemented. These orders occurred between 11/11/11 and 3/16/12. For two, no physician order was required. For one submission, there appeared to be several concerns requiring physician review and closure. However, there was an order for one concern, dated 3/13/12, but no orders were submitted for some of the other concerns	Noncompliance

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		listed. There may have been discussion in the Integrated Progress Notes (IPNs) or elsewhere in the PNMT files, but this was not submitted. However, from review of these PNMT assessments/follow-ups/updates, it appeared there was a process in place for PCPs to incorporate PNMT recommendations into the individual's care. Some of the recommendations appeared to not be clearly tracked to closure, especially if the PCP did not agree or had alternate plans with justification. Any PNMT recommendations requiring physician orders or responses from nursing staff, such as modification to the care plan, should be tracked until completion/implementation. It was noted in the Facility's Self-Assessment that a database to track PNMT activity/recommendations through the morning medical meeting had not been developed, but had been identified as a goal. The Medical Compliance Nurse summarized the consult reports the PCPs received and reviewed, and they were discussed at the morning provider meeting on a daily basis. This provided the opportunity for all PCPs to be updated concerning the consultation reports, and allowed the RN Case Managers to take this information back to the IDT members. For a period of time, a representative from Laboratory had been attending once weekly, and provided a report of tests that had not been completed. This Laboratory representation had then stopped, but was to resume in the near future. It is recommended that a member of psychology (either one psychologist appointed to attend regularly, or each psychologist attending on a rotating schedule) attend to contribute expertise in behavioral issues. As part of the morning provider meeting, skin integrity was reviewed on a weekly basis. The Infection Control Nurse also provided updates on a weekly basis. The Hospital Liaison Nurse reported daily any individual admitted to the hospital. The unit RN Case Managers communicated concerns that needed IDT participation to the QDDP. These positions were to change in the near future, and the Facility should ensure continuation of the communication process to the QDDP. At the time of the Monitoring Team's visit, the nurse case manager forwarded the information to the QDDP, who in turn organized an IDT meeting to discuss the concern. The resulting ISPA was then potentially available for the Medical Compliance Nurse to review. It is recommended that the recommendations from the morning the provider meeting be tracked through to the completion of the ISPA, and that the ISPA be brought to the morning provider meeting for review. This is important to ensure that the integration of clinical services begun at the morning provider meeting reaches the level of the IDT and, most importantly, the individual. The Medical Compliance Nurse had initiated this process of tracking ISPAs, but the tracking process was only in the initial stages of development.	

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		Currently, the Medical Department was not tracking the recommendations through to ISPA completion. In addition, as noted with regard to the Facility Self-Assessment, for Section G.1, the Facility had focused on the role of the Medical Department, which was pivotal. However, all clinical departments are essential in providing integrated clinical care, and each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus. The role of the IDT is essential, and measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. Also, there is considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the Integrated Risk Discussion Results, the Risk action plans, the implementation steps taken, and the outcomes. This could be tracked for stable conditions as well as changes in health status. At the time of the Monitoring Team's visit, no data was available to measure many of these components that demonstrate integrated clinical care.	
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 one to seven consultations per individual. A total of 47 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 47 reviewed, 44 (94%) had PCP initials and date, indicating review of the consultant report. For one of the consultations, the consultation report was not submitted to confirm the initials and date reviewed by the PCP. ▪ To improve compliance, the consult reports were stamped with a box for the PCPs to complete to clarify agreement/disagreement with the consultant recommendations. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs were reviewed. Of the 47 reviewed, 45 (96%) consults included documentation of agreement or not with the consultant recommendations. ▪ There was a range of time between the date of the consult report and the date of the PCP's IPN review of the consult. This varied from the same day the consult report was written to 79 days after the date of the consult report. ▪ For the 47 reviewed, there was no ISPA that addressed the submitted consultation (0%). For one, there was a post-hospitalization ISPA that occurred prior to the submitted consult, but did not provide evidence the IDT met concerning the consultation, or that the team discussed changes in risk rating, or	Noncompliance

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		implemented any necessary action steps. The request for documents included copies of any ISP addendums that were related to the submitted consultations. The lack of information indicated either that the request was not interpreted correctly, or no system was in place to ensure that IDTs were aware of and discussed consult reports. Consult reports were routinely discussed at the morning provider meeting, and reportedly, a system was in place through which the RN Case Manager discussed these promptly with the QDDP and/or IDT (ideally later that morning). However, there was no proof this currently occurred, because no ISPAs were submitted reflecting IDTs' discussion. As a result, a significant gap remained in demonstrating integrated care to the individual. The Medical Compliance Nurse tracked the consultations, agreement/disagreement/ recommendations, and whether they were addressed at the morning provider meeting. It was not clear if this endeavor was placed on hold during the absence/leave of the Medical Compliance Nurse, or whether it continued. A sample of "off campus visits by specialty" was submitted. It included tracking of consultants for appointment completion, reports received at the Facility, whether the PCP reviewed them, and whether there was evidence of agreement with recording of any orders or action steps. The sample was taken from 11/1/11 through 1/1/12. The Facility did not submit a more recent sample for review. This appeared to be a valuable monitoring tool if used consistently. A future step the Medical Department identified was tracking the consultations that required a physician's order and incorporating this information into the database. This would identify any outstanding recommendations needing a physician order, and notification of the PCP would follow. This process was to be in place by 7/1/12. Additionally, the Medical Compliance Nurse was to review the PCPs' timely review (within five business days) of all consult recommendations. This remained a future identified goal. Copies of the consult reports were forwarded to the IDT for review. Based on the consult report, the IDTs were supposed to review the risk level, and services and supports needed to implement the recommendations, along with an action plan if indicated. However, ISPAs were not forwarded back to the morning provider, and discussion was not occurring to ensure that the IDT response was thorough in meeting the needs of the individual and in addressing the concerns identified in the morning provider meeting.	

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

1. For the morning provider meeting, an attendance roster participants' sign-in sheet should be maintained to ensure accuracy of the roster listed in the meeting minutes. (Section G.1)
2. As a measure of integrated care and integrated discussion, a system should be established to track departmental representation at the morning provider meetings. (Section G.1)
3. Any PNMT recommendations requiring physician orders or responses from nursing staff, such as a modification to the care plan, should be tracked until completion/implementation. (Section G.1)
4. Laboratory staff should attend the morning provider meeting at periodic intervals to discuss individuals unable to cooperate with lab testing (drawing blood, etc.). (Section G.1)
5. A member of the Psychology Department (either one psychologist appointed to attend regularly, or each psychologist attending on a rotating schedule) should attend the morning provider meetings to contribute expertise in behavioral issues as well as act as a liaison with the Psychology Department. (Section G.1)
6. When appropriate, the recommendations from the morning provider meeting should be tracked through to the completion of the ISPA, and the ISPA be brought to the morning provider meeting for review. (Section G.1)
7. Each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus. (Section G.1)
8. When IDT involvement is necessary to address the results of a consultation report, the follow-up ISPA should be reviewed at the morning provider meeting to ensure the IDT response is thorough and meets the needs of the individual. (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: o **Review of Following Documents**: o Presentation Book for Section H; o Five DG-1s from each residence; o Documentation/justification of four active diagnoses for each of four individuals on each PCP's caseload; o **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Melody Morton, RN, Clinic Manager.
	Facility Self-Assessment: Based on the Facility's Self-Assessment, the Medical Department had undergone two external peer review audits that began to track both medical documentation and medical management. The Medical Department indicated the PCPs were completing quarterly medical assessments, with submission of data indicating that 14 of 15 residences had completed these reviews, and 53% were completed in a timely manner. According to the Facility, for annual medical assessments, 82% had been completed in a timely manner, and the DG-1 forms provided an ICD code for each diagnosis. However, the Monitoring Team's data did not show improvement in the rates of annual medical assessment completion. This is discussed in further detail with regard to Section L.1. The compliance rate was only 51 to 55%. Further, when active records were reviewed for 18 individuals, none had quarterly medical reviews. In addition, there was no data collection to provide evidence that the diagnoses fit the evaluations and physical findings of the individual, and met established ICD criteria or guidelines from nationally recognized professional organizations. On site, a member of the Monitoring Team collected data and summarized the information to confirm compliance, but the Medical Department should have completed this process. As the Facility's Self-Assessment indicated, external medical peer review data was available from November 2011. However, the Self-Assessment did not adequately analyze this data. It merely provided one overall score without any delineation of specific areas requiring improvement. In addition, the reviews were not analyzed longitudinally. The same deficiencies appeared to keep reoccurring, as noted from the August, November and February 2012 audits, but there was no tracking of repeat deficiencies and no discussion from medical staff concerning ways to reduce the deficiencies. Common clinical elements of care include all clinical departments, not just the Medical Department. However, the Facility's Self-Assessment included no data to demonstrate other departments were providing necessary clinical care according to their specialties (e.g., Nursing, Dental, PT, OT, Speech, Psychology, etc.). The Facility did not include any data regarding the efficiency and effectiveness for each department in meeting the needs of the individuals, especially individuals with changes of health status or behavioral status. For newly identified concerns, the five-day window to begin the assessment process was

	not monitored for compliance, according to each department's participation. To ensure no gaps in clinical services, the Facility should track the implementation of each plan based on an identified risk, and analyze data by clinical department. Some areas such as frequent falling, decubiti, or pica would require many departmental services, and others less. Similarly, for changes in health status, the clinical services that the IDT determined to be necessary should be tracked to ensure these elements of clinical care are offered. At this time, there remained no evidence that a minimum of necessary clinical services were provided to address the individuals' needs and minimize to the extent possible the risks to individual's health. The Facility indicated in its Self-Assessment that it was in compliance with Section H.2, but remained out of compliance with the remaining provisions of Section H. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Facility continued to strive toward comprehensive quality care. Routine periodic reviews were essential to the care of those residing at LBSSLC. However, the Facility still struggled with completing annual medical evaluations in a timely manner. The timely completion of quality medical quarterly progress notes could not be confirmed through the records submitted. In addition, this section is interdisciplinary, and the Facility should submit evidence of timely assessments and treatment across all of the clinical disciplines. Providing evidence of required common clinical elements of care for both acute and chronic illness remained a challenge to the Facility. Medical response to acute care needs appeared to be appropriate. However, there were concerns related to direct support professionals and nursing staff's lack of recognition of change in individuals' health status, as well as nursing staff's lack of timely assessment, with applicable documentation. The State Office clinical guidelines recently had been implemented. Additionally, the external medical peer review, with its medical management component, offered further guidance with choice of clinical indicators and measurement tools for quality medical care. However, the Facility did not yet have a system to capture information related to these clinical indicators or use such information to routinely improve services provided.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals'	The Medical Department submitted a document listing the annual physical evaluations completed according to annual due dates of 365 days from the prior annual physical evaluation. The calculated completion rate was 82%. This completion rate was greater than the rate the Monitoring Team calculated based on a review of submitted information. However, the Facility list appeared to reflect only the 2011 data, and the Monitoring Team reviewed more current information. This is discussed in further detail with regard to Section L.1. Additionally, the Facility submitted a document that tracked the completion rate of	Noncompliance

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	needs.	quarterly medical reviews. Each individual's last quarterly was entered, and the conclusion of the analysis was that the completion rate for medical quarterly reviews was 53%. However, a member of the Monitoring Team reviewed 18 active records. No medical quarterly reviews were found in any of the 18 individuals' records. The reason for this could not be determined. Initial detection of health status change was dependent on the training and ongoing involvement of the direct support professionals and the Nursing Department. As discussed with regard to Sections L.1 and L.2, concerns were identified with the timely determination of health status change and nursing staff's preliminary assessment. The medical staff, once notified of a change in health status, appeared to have a rapid response. The Medical Compliance Nurse was assigned the task of tracking responses to health status change. This, in part, was done through the morning provider meeting process as part of closure to concerns. With the development and implementation of clinical guidelines, the response to health status change, depending on the problem, should become more uniform across the campus. Parts of these clinical guidelines can be used as clinical indicators of improvement or measurement tools to determine adequacy of treatment. However, Section H.1 includes all elements of clinical care. As is discussed in the various sections of this report, issues remained with both the timeliness, and particularly the quality of assessments and evaluations. The QA Department should ensure each clinical department measures progress in the timely completion of required monthly, quarterly or annual assessments and forms. Attendance should be tracked at interdisciplinary meetings. Other clinical indicators of integrated care of these common elements should be developed. The clinical guidelines might assist in developing a blueprint for evaluation. For example, for a given diagnosis, there should be evidence that the needed disciplines provided assessments, that the team discussed these evaluations, and that the essential elements for care for that diagnosis were included in a corrective action plan. As indicated, this should include psychology, psychiatry, medical, dental, nursing, habilitation therapies, dietary, and pharmacy. The Medical Department had a computerized database for clinic visits and other PCP encounters. From the list of areas currently monitored through the database, the PCP's response to health status change and acute illness was not included. This would appear to be important information to collect and analyze.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the	The Facility indicated no in-service training had been provided to the PCPs concerning the nomenclature/diagnoses used in the ICD and DSM systems. However, a current ICD manual was available for PCP use in the clinic area. The Medical Director confirmed that the most specific applicable diagnosis was used, and that classifications of not otherwise	Substantial Compliance

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	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.	specified (NOS) and not elsewhere classified (NEC) generally were not used. To provide evidence for this section, information was submitted for four individuals on each PCP's caseload. Four active diagnoses were chosen from the active problem list for each individual, and documentation was submitted to provide justification of the diagnosis. The evidence included a wide range of information, including consult reports and specific test results. In all 16 cases, the diagnoses clinically fit the submitted assessments/evaluations/test results. To confirm that the most specific applicable diagnosis was being utilized, five DG-1s were submitted from each residence. Completed DG-1 forms were submitted for five individuals living in each of 15 residences for a total of 75 DG-1s. The DG-1 included the ICD codes most applicable to the diagnosis. The more specific the diagnosis the PCPs submitted, the more precise and accurate the ICD coding. Measurement of the presence or absence of nonspecific diagnoses, indicated by "NOS" was reviewed for Axis III diagnoses. When sufficient assessment was completed, there were often clear criteria to determine diagnoses that did not require the qualifying "NOS" after the diagnosis. As the Medical Director noted, the 75 DG-1s did not include any diagnoses of "NOS" for Axis III. There was only one psychiatric diagnosis (Axis I) that included an "NOS" on the DG-1. In summary, of the 75, 74 (99%) did not include an "NOS" in the Axis I section of the DG-1. The review of the DG-1s, along with the criteria identified for the diagnoses submitted on the active problem lists, indicated compliance with this section in relation to the ICD/medical diagnoses. In addition, as noted with regard to Section J of the Settlement Agreement, review of the psychiatric diagnoses for 20 individuals who were receiving psychotropic medication found that for 18 of the 20 individuals (90%) contained adequate documentation to justify the individuals' psychiatric diagnosis. Further information is provided with regard to Sections J.2 and J.13 of the Settlement Agreement. It was noted that the DG-1 form might not be adequate in providing for all the significant diagnoses for Axis III. The State Office should consider a review of the layout of this form. Adding additional lines to the Axis III section might provide more complete information concerning diagnoses per individual. Conversely, in the DG-1 forms reviewed, the Axis I and Axis II dedicated space was underutilized, and would be better used if Axis III space was expanded to include the unused space of these other Axes.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two	As discussed with regard to Section H.2, the medical diagnoses of the individuals appeared to have sound clinical evidence supporting their accuracy. Section H.3 focuses on timely and appropriate treatment. LBSSLC had utilized internal and external audits to	Noncompliance

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	years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	monitor and ensure timely clinically appropriate treatment. Since the last Monitoring Team's last visit, the external and internal peer review audits occurred twice. Additionally, the most recent external peer review included a medical management component for three diagnoses (i.e., diabetes mellitus, osteoporosis, and pneumonia). Starting in February 2012, the medical management components were to be different at each peer review audit, and would be derived from a set of questions for each of six different diagnoses common to the IDD population. The results of these audits provided feedback to the Medical Director and the PCPs concerning adequacy and timeliness of treatment. Additionally, the State Office created and distributed a series of clinical guidelines that included diabetes mellitus, enteral feedings, Urinary Tract Infections (UTIs), constipation, aspiration pneumonia, osteoporosis, and seizures. Some of the audit questions were derived from these. However, the rich content also allowed Medical Department as well as for the Facility QA Department to identify and use many clinical indicators. The Facility had not yet developed such a set of clinical indicators. These clinical guidelines could be used to review clinical care in these areas throughout the year and not just at the six-month interval of time allotted to the external and internal reviews. In addition, the State Office should create clinical guidelines for other diagnoses common to the IDD population. Such guidelines would be helpful in the provision of care and treatment. They also would further identify clinical indicators to measure quality treatment. As part of the expectations of care in treating specific diagnoses, the PCPs were provided an in-service training on the following clinical guidelines: diabetes mellitus, seizures, osteoporosis, urinary tract infections, and enteral feedings on 2/9/12, and 3/16/12; and constipation/bowel management, and reducing the risks for aspiration pneumonia on 2/9/12.	
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 content of the clinical guideline for diabetes mellitus, there were a number of "process indicators" in the form of questions, which assisted the reviewer/auditor in measuring the quality of clinical care for that diagnosis. For instance for diabetes mellitus, there were "process indicators" for recognition, assessment, treatment, and monitoring. This outline of process indicators was followed by several pages of guidance focused on the different roles and expectations of the PCP, nurse, and direct support professional in assisting the individual in treating diabetes mellitus. Many of the subtopics had information from which clinical measures could be created and applied when monitoring care. These guidelines could be utilized in developing tools to measure the provision and effectiveness of the treatments and interventions. Such tools could be	Noncompliance

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		applied to the role of the Medical Department, as well as the Nursing Department, and the direct support professional in the clinical care of the individual for specific diagnoses. As part of the orientation, the nurse education department taught the new direct support professionals about changes in health status, and these guidelines provided further information helpful to the direct support professional in observing for changes in health or signs and symptoms that require prompt notification of the nurse. At the time of the Monitoring Team's review, systems to measure such clinical indicators were not yet in place. As a result, the Facility remained out of compliance with this provision.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility focused on an example of diabetes mellitus in creating a system approach to monitor the health status of individuals. The Facility submitted a list of 14 individuals with diabetes mellitus who reside at LBSSLC. A sample flow sheet that LBSSLC was beginning to use for monitoring health status and maintaining quality care was submitted. It was entitled: "Physician Consortium for Performance Improvement: Adult diabetes care physician performance measurement set. Prospective Data Collection Flow sheet." This provided a chart of potential indicators to be followed that would provide monitoring of the many body systems affected by diabetes mellitus, and provided a measurement of the quality of care for many aspects of this chronic illness. Other flow sheets for the other five diagnoses for which clinical guidelines were created did not have a measurement monitoring system such as the diabetes flow sheet. The Medical Department is encouraged to develop process indicators of recognition, assessment, treatment, and monitoring similar to the diabetes mellitus clinical guideline for the other clinical guidelines. Each diagnosis that has been chosen for the development of clinical guidelines is unique. Although clinical indicators of adequacy of medical care and health status of the individual might include laboratory testing, this might not apply to such diagnoses as constipation, or aspiration pneumonia. In these latter diagnoses, documentation of completeness of assessment/procedures and response to the results, as well as appropriate consultations answering specific PCP concerns, might be chosen as clinical indicators that can be measured. As an alternative, the medical management audits for the internal and external reviews included questions to monitor the effectiveness of care of these health conditions. These would provide a measure of health status monitoring of quality of care. By using other parameters derived from the clinical guideline, changes in health status for some conditions could be developed further. The State Office created a yearlong schedule for twice-yearly audits of the medical care for six common diagnoses. Through the clinical indicators utilized in these six medical care audits specific to the diagnoses, including various serial diagnostic tests, completion of expected consultations, follow-up to test	Noncompliance

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		results, and timely treatment, the ongoing quality care of the individual could be determined. Separately, medical care monitoring should not have to wait for audits that occur every six months. The Medical Department should monitor the quality of medical care on an ongoing basis. It is recommended that trends in medical care (e.g., diagnoses, complications, hospitalizations, change in incidence, review of preventive care flow sheets, etc.) should be reviewed monthly/quarterly to monitor the quality of medical care directly. The external and internal audit systems identified concerns needing improvement. The QA/QI Department was responsible for entry of the raw data the auditors collected, and distribution of a printout of corrective action plans for each deficiency. For each PCP, a list of action plans was distributed designed to correct each concern on each of the individual's for which an audit was completed. These were tracked monthly until completion. The audits from August 2011 and November 2011 were followed serially, with demonstration of progress in correcting these outstanding issues, as well as listing the areas that remained uncorrected. One of the problems, also mentioned elsewhere in this report, was the lack of identification of the date of the audit to which the information referred. This made it more difficult to interpret, given the series of audits completed at LBSSLC. In the future, it would be helpful for each page of any monitoring tool document or any monitoring results to have the date of the audit, as well as the current date to which updated information applies. The February 2012 audit included a printout of corrective action plans per PCP, along with the date by which the correction was expected to occur. The risk management process also had potential for significant impact on monitoring the health status of individuals. The risk ratings and risk action plans were incorporated into the action plan section of the ISP. This included a column indicating the diagnostic risk category and the level of risk. This ideally would be used as a blueprint by the IDT and, especially the QDDP, in measuring stability of health and progress in following the plan. However, the Facility was only in the beginning phases of developing this at-risk program. There was beginning to be quality interdisciplinary discussions with some of the IDTs. However, some of the ISP documents did not indicate quality interdisciplinary discussion. Monitoring individuals using meaningful clinical indicators remained a challenge for all teams. For the majority of individuals, there was no information based on clinical indicator measurements that demonstrated success of the IDT's action plans. Consultation reports, ER visits, and hospitalizations should have generated the need for a team meeting to discuss change in risk level and development of steps to minimize the risk. An additional step for monitoring health were the many periodic or serial assessments completed by the various clinical departments. For instance, the Medical Department	

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		reportedly routinely completed an annual exam, and quarterly medical reviews, as well as reviewed and signed the Quarterly Drug Regimen Reviews. As noted later with regard to Section L, Medical Department had much work to do, because completing the annual exams in a timely manner remained a challenge. Additionally, none of the records reviewed included a quarterly medical review. As this section was multi-disciplinary, every clinical department should have provided evidence of its participation in ensuring common elements of clinical care were provided to each individual when indicated. For example, as noted above, there remained challenges in the Nursing Department and in the residential services in identifying health status change at an early stage, and providing appropriate monitoring once a concern was identified. In addition, the at-risk process had not yet developed to the phase of being able to identify and/or monitor the clinical indicators necessary to show whether or not individuals' action plans were successful.	
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.	The Facility determined that it had not started on this section. This section requires long-term progress with the previous subsections of Section H. This section will require demonstration of a functional system that is both integrated and provides the full spectrum of all elements of clinical care. The various protocols developed by the State Office represent an initial framework for this section, but there needs to be evidence that these are put into action, and that treatment reflects ongoing interventions and changes in interventions based on identified clinical criteria/clinical indicators that are appropriate for the individual. Evidence for this is anticipated to occur based on reviews of the morning medical meeting minutes, as well as the internal and external audit reviews of clinical care. Discussions at the morning meetings should include reviewing the changes (deterioration) in health status reported. This should lead to a review of current treatment interventions, and discussion of potential modifications guided by the clinical guidelines. Use of related clinical indicators would be helpful in tracking progress. With the clinical reviews being added to the internal and external audit processes, measurement also will begin regarding whether or not the Facility is responding to changes in health status (for the condition reviewed). This process also will assist in measuring improvements the Facility makes over time. However, at this point in time, no evidence was provided, because these audits had just begun.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical	The Medical Department continued to create policies and procedures to improve medical care. The LbSSLC – Health Services: Preventive Medicine policy was implemented 3/2/12, which included a revised preventive health screening form with room for comments. On 3/6/12, the PCPs were in-serviced on the policy. Other clinical policies and procedures are discussed with regard to Section L.4.	Noncompliance

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	services policies, procedures, and guidelines to implement the provisions of Section H.	This was a first step toward compliance with this section. The seven clinical guidelines provided standardization to seven common clinical conditions in individuals with Intellectual/Developmental Disability (IDD). Additionally, the preventive medicine policy provided direction in many areas of healthcare in preventing illness, and provided a standard of care. However, these guideline/policies had only been recently approved. The Medical Department did not submit evidence concerning the degree to which they had been implemented. The external audit did include a review of three of the diagnoses in establishing a baseline. However, the data collected and the critical questions reviewed for any monitoring process will need to reflect the content of these clinical guidelines and policies. Trends from these serial assessments will need to show improvement in the Facility's adherence to the clinical guidelines and policies. Additionally, many other areas of healthcare will require creation and implementation of policies and guidelines. There are other common conditions in the IDD population for which standardized care and guidance and a minimum level of expectations should be developed and implemented. Additionally, other integrated clinical policies should be developed or modified, such as the addition of procedures for the tracking of PNMT recommendations, and the tracking of morning provider meeting recommendations through the IDT process and ISPA process back to the morning provider meeting, and the development of formal policies on missed or refused appointments, ethics committee deliberations and format, etc. Some of these processes appeared to have been created, but had not been finalized in a policy or procedure format. Such policy formation allows other departments to create parallel policies, and administration would then need to ensure consistency and agreement in roles and jurisdiction, and include expectations of communication and documentation of integration through meetings, task forces, procedures, minutes, etc. This section requires all clinical departments, not just the Medical Department, to undergo policy, procedure, and protocol review (through Facility administrative efforts) to determine the gaps of each department in providing integrated clinical services. These components include creating the policies/protocols, training and implementing them, choosing clinical indicators that can be measured, and monitoring for success. Within the policy framework, guidance should be provided regarding the integration of expertise, flow of information and meetings, committee structure and responsibility, the content of minutes, and the method of attendance tracking.	

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

1. The QA Department should work with each clinical department to ensure measures are developed regarding the timely and adequate

completion of required monthly, quarterly, or annual assessments and forms. (Section H.1)

2. Attendance should be tracked at interdisciplinary meetings. (Section H.1)
3. For a given diagnosis, evidence should be available that the needed disciplines provided assessments, that the team discussed these evaluations, and that all essential elements for care of that diagnosis have been included in an integrated action plan. (Section H.1)
4. The Medical Department should measure the adequacy of PCP response to health status change and acute illness. (Section H.1)
5. All clinical areas, including nursing, psychology, psychiatry, habilitation therapy, etc., should provide evidence that routine quality assessments are completed in a timely manner, as well as evidence of timely response to changes in health status of the individual. (Section H.1)
6. The implementation of the risk action plans of the individuals should be tracked by the Facility to determine the involvement of each clinical department that might have impact on that risk, as a method to provide ensure that individuals have adequate access to the minimum common elements of clinical care. (Section H.1)
7. The State Office should create clinical guidelines for other diagnoses common to the IDD population. (Section H.3)
8. The Facility should develop a set of clinical indicators/outcome measures to assist in determining if treatments and interventions are implemented and effective. (Section H.4)
9. It would be important for each page of any monitoring tool document or any monitoring results to have the date of the audit, as well as the current date to which updated information applies. (Section H.5)

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

1. The State Office should consider a revision to the layout of the DG-1 form to allow inclusion of more diagnoses listed under Axis III. (Section H.2)

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: o **Review of Following Documents**: o DADS SSLC "Risk Guidelines" laminated record; o LBSSLC Presentation Book for Section I; o LBSSLC's Self-Assessment; o LBSSLC's Provision Action Information, and Action Plans; o LBSSLC At-Risk Individuals list; o LBSSLC Section I Presentation for Monitors' 4th Compliance Visit March 2012: o At-Risk Guidelines and tool; o LBSSLC Section I Workgroup summary for meetings dated 1/17/12, 1/24/12, 1/31/12, 2/7/12, 2/28/12, and 3/6/12; o Risk Workgroup Tasks, Purpose, and Focus; o LBSSLC Individual Support Plan-At Risk Process (draft); o LBSSLC Risk Rating Data by home; o LBSSLC Admission/Discharge Procedures for 504 E. Mesquite, Acute Care Facilities, and Emergency Room Visits (draft); o Communication Process – Providing Hospitalization Information to Interdisciplinary Teams, undated; o Interdisciplinary Team Training Process curriculum (draft); o Timely Filing of the Integrated Risk Rationale in the Active Record procedure and tracking data; o Section I raw data audits and data graphs; o Quality Assurance Director documentation regarding the current inter-rater reliability process; o The following documents: Occupational and Physical Therapy Assessments, Speech Language Pathology Assessments, Integrated Risk Rating Forms, and Action Plans for Risk Assessments for the following 20 individuals: Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #9, Individual #74, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149,Individual #139, Individual #323, Individual #128, Individual #16, Individual #199, Individual #104, and Individual #324. o DG-1; most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past one year of any IPN pages with PCP entries; past one year of labs, x-ray reports, scans, MRIs, and ultrasound reports; hospital discharge summaries for past one year; ER reports for past one year, consult and procedure reports for past on year; DNR form, if applicable; physician orders for past one year; most recent PSP/ISP and subsequent addendums; most recent BSP; most recent integrated risk action plan; and attendance roster for the following individuals: Individual #52, Individual #276, Individual #204, Individual #6, Individual #203, Individual #74, Individual #34, Individual #23, Individual #17, Individual #111, Individual #113,

	Individual #269, Individual #143, Individual #298, Individual #324, Individual #315, Individual #198, and Individual #84. o ISPAs for the following individuals hospitalized during the last six months: Individual #226, Individual #226, Individual #312, Individual #136, Individual #6, Individual #43, Individual #41, Individual #41, Individual #281, Individual #281, Individual #74, Individual #23, Individual #211, Individual #237, and Individual #161; and o Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following 22 individuals: Individual #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, and Individual #276. o **Interviews with**: o Robin Seale, Assistant Director of Programs (ADOP); o Don Minnis, RN, BSN, Chief Nurse Executive; o Latrell Castanon, RN, BSN, Physical Nutritional Management Team; o Danette Mitchell, Residential Coordinator; o Susana Cantu, RN, Case Manager; o Melody Morton, RN; o Heath Henry, Unit Director; o Cynthia Rodriguez, Residential Services Clerk; o Sandra Kennedy, QDDP Educator; o Carolyn Milton, BCBA, Assistant Director of Behavioral Services; o Debbie Jones-Ellison, Speech Language Pathologist (SLP); o Corey Verett, MS, Registered Dietician (RD), Licensed Dietician (LD); o Missy Olive, Physical Therapy Assistant (PTA); o Linda Thomas, Occupational Therapist – Registered (OTR), Habilitation Therapies Director; o Jeremy Ellis, RN, QE Nurse; o Eddie McFadden, RN, QE Nurse; o Dawn Ripley, QA Director; and o Sally Schultz, State Consultant. ▪ **Observations of**: o ISP meeting for Individual #98, on 3/19/12; o ISP meeting for Individual #259, on 3/20/12; and o ISP meeting for Individual #51, on 3/22/11.
	Facility Self-Assessment: The Facility's Self-Assessment indicated that "based on the findings of the self-assessment this provision is not in compliance due to significant variances in monitoring data and lack of inter-rater reliability. Accessibility of the most current risk assessments continues to be an issue as well."

	Since the last review, LBSSLC's Self-Assessment, and Provision Action Information documents indicated that the following steps had been taken to assess the At-Risk process: o A review of risk data by home was conducted to determine if all individuals had a risk assessment completed, and found that all 221 individuals had received a risk assessment within the last 12 months. o The Facility reviewed the Individual Support Plan, Risk Discussion, and Risk Filing Status tracking information to determine if regular risk assessments were accessible in the active record. The review findings indicated that of the 221 risk assessments completed, 90% (198 of 221) were available in the active record. However, the Facility found that auditing had not occurred for 11 of the assessments. Therefore, the compliance score in the Facility's Self-Assessment was not accurate. In addition, the Facility reported that while risk assessments were available, its auditing data indicated that only 81% (179 of 221) were the most current assessment. However, the Self-Assessment made no mention of the status of the 11 risk assessments that had not been audited. As a result, these data could not be interpreted. o A review of the departmental monitoring for Section I found the following overall compliance scores: 7/11, 3%; 8/11, 88%; 9/11, 56%; 10/11, 45%; 11/11, 40%; and 12/11, 11%. The Facility indicated in its Self-Assessment the significant variance in the overall monitoring tool compliance made it impossible to determine corrective action, and current processes were under revision to move toward increasing compliance and consistency. However, as mentioned in the Monitoring Team's previous reports, assessing compliance based on a single compliance percentage score virtually had no meaning without items being weighted according to clinical priority, and importance. Thus, the Facility presented no relevant data to substantiate its findings of noncompliance, or to assist the Facility in identifying the areas requiring attention, and corrective action. o The Facility reviewed its inter-rater reliability data to determine the validity of its compliance percentages for Section I monitoring conducted by the "department" (the specific department was not reported in the Self Assessment) and the Quality Assurance Department. The Facility reported that the Section I monitoring inter-rater reliability scores for the past six months were as follows: 7/11, 96.5%; 8/11, 48.5%; 9/11, 63.5%; 10/11, 60%; 11/11, 66.5%; and 12/11, 86.5%. The Facility indicated that inter-rater reliability had varied over the past six months, but the increases during the last three months might have been a result of monthly meetings between the "department" and QA. However, documentation provided by the QA Director indicated that the Facility was in the beginning stages of developing an inter-rater reliability process, and that although for Section I, the Department along with QA was monitoring the same sample at the same time, the process was focused on the development of instructions for the monitoring tools. Based on staff interview, the Facility's Action Plan for Section E indicated that August 2012 was the anticipated date for implementation of a process addressing inter-rater reliability. The development of specific instructions was an appropriate and crucial first step before inter-rater reliability could be established. Given that this piece was not yet in place, the current reported percentages for actual inter-rater reliability were not accurate or reliable. At this point, data generated from the Section I tools could not be accurately interpreted. Although the Monitoring Team's findings supported the Facility's finding that it was not in substantial compliance with the Settlement Agreement requirements for Section I, it was not clear from the Facility's Self-Assessment what specific criteria was used to determine compliance. Aside from the data addressing

	the completion of the risk assessments, there was no indication that the quality and accuracy of the risk assessments were evaluated as a component of compliance. In addition, no explanation was provided regarding what specifically the single compliance scores that were reported in the Self-Assessment represented or reflected regarding areas of strengths, weaknesses, and the progress of specific areas from month to month.
	Summary of Monitor's Assessment: The Facility appointed a new leader for this section. A working group was convened to determine the future direction. A set of questions and document references were created to assist the teams in providing justification for each risk category. The Facility determined that little evidence was available in the active records to show that teams met the five-day timeframe for beginning the assessment process according to the needs of the individual, and the 14-day period for implementation of the plan. This was consistent with the findings of the Monitoring Team. A review of the risk process indicated a wide variation in quality. Some IDTs used the Integrated Risk Rating Form, while other teams used the Integrated Risk Discussion Results form. In addition, there were inconsistencies regarding the Risk Action Plans being placed in the ISP. However when they were, they were difficult to find at times. This would appear to have created a barrier to their use. The newest risk screening documents had considerably improved justification, but these also were found to be inconsistent. Regarding the Risk Action Plans, little improvement was found regarding the quality of the plans. An additional concern was the lack of follow-up to ensure the plan was actually being implemented. Also of mounting concern was the fact that during every review, major pieces of the At Risk process were under construction rendering it difficult to identify the exact clinical interventions and when they were provided to the individuals.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Based on an interview with the Facility's Section Lead for Section I, and members of the Risk Workgroup, and review of the Facility's Provision Action Information, the following were steps forward that the Facility had taken since the last review to address the At-Risk process: o In November 2011, the Section I Lead was reassigned from the Medical Director to the Assistant Director of Programs. o In an effort to increase communication, in December 2011, the ADOP's Administrative Assistant and Clerk began attending the morning provider meetings, and sending information regarding changes in status of individuals to their IDTs. o In January 2012, the Facility developed a Risk Workgroup to address issues related to the At-Risk process and revised action plans for Section I of the Settlement Agreement. A review of a document summarizing the meetings of the workgroup found that the Facility had identified some promising actions	Noncompliance

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		regarding clarifying, and revising Facility procedures, such as the Individual Support Plan, and the At Risk Process, and had detailed some discipline roles, responsibilities, as well as the referral process to the Physical Nutritional Management Team, and the Behavior Support Committee. Although a discussion with the ADOP, and members of the Workgroup provided the Monitoring Team more details regarding the activities of the Workgroup, no formal minutes had been maintained regarding these meetings. The Facility should consider maintaining formal minutes of the Risk Workgroup meetings. Such minutes should outline clearly the specific information discussed, responsibilities assigned, timeframes for completion of activities/assignments, dates of actual completion of activities/assignments, outcomes, and any further monitoring activities needed to assess outcomes. Although this was a promising step forward, a review of the documentation indicated that of six Risk Workgroup meetings scheduled between January and March 2012, three were canceled. o However, some of the activities of the group thus far included: o As part of the work group activity, a draft of an updated risk process was submitted. It was entitled: " LbSSLC - IDT Process – Program Development: Individual Support Plan – At Risk Process." This was designed to update the risk process policy currently in place. o As part of the improvements, an "Integrated Risk Discussion Results" form was created. The State Office "Risk Guidelines" continued to be used. However, for each area of risk, probes were listed to ensure the IDT reviewed each aspect and provided a response in the document. This assisted with the justification of the risk rating. o In an email dated 3/6/12, a system of training on the risk rating and action plan process was reviewed. A draft of the "Interdisciplinary Team Training Process" was submitted. For each risk area, a list of bulleted questions was provided for which the response would be included in the risk rating section of the appropriate category of risk, and included both the documents to be referenced or reviewed for the integrated risk rating form rationale, and the risk action plan objective/goal, and action steps. o A compliance monitoring form was created (in draft form). o As a measure of validity, the Facility data collected through other mechanisms (e.g., pneumonia reports, weight reports, etc.) would be compared to the high and medium risk lists. If discrepancies were noted, the IDT was to resolve the concern. The risk workgroup was to review the data monthly. o A determination also was made that not all the integrated risk rationales were filed in the active record and were not available for use.	

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		A workgroup convened to create an improved process to ensure that once filed, the document remained in the record. o In addition, in January 2012, the completion of the risk monitoring tools was reassigned from the Medical Program Nurse to the ADOP, and an Action Plan addressing Section I was finalized. However, departmental monitoring was suspended to allow more time to focus on the risk process, and the Action Plan for Section I was also discontinued to focus energies on the Action Plans for at-risk individuals. Since February 2012, the monitoring of Section I was conducted solely by the QA Department. However, from the information included in the Facility's Self-Assessment noted above, it was unclear if the development of the instructions for the Section I tools were actually completed in order to generate more accurate data regarding the At-Risk system. o In November 2011, the IDT from 504 E. Mesquite developed integrated care plans for six of their most medically complex individuals. However, from discussions with the CNE, and ADOP, significant system and discipline barriers resulted in poor follow-thorough regarding the interventions the team developed. Thus, at the time of the review, the plans had not been adequately implemented. o At the time of the review, the Facility was in the process of developing training regarding individual risk factors for the direct service professionals. Since the last review, although the Facility had implemented some positive steps in its efforts to move forward regarding this requirement of the Settlement Agreement, the Monitoring Team found that little progress had been made in this area, and that the Facility continued to have a significant amount of work to do to achieve compliance with this requirement. From previous discussions with the State's Consultants addressing the At-Risk system, the State was considering a number of changes regarding the current At-Risk process. These changes would alter some of LBSSLC's procedures regarding the At-Risk process. To assess the Facility's risk screening process, while on site, members of the Monitoring Team observed three individuals' ISPs meetings (i.e., for Individual #98, Individual #259, and Individual #51). Specifically, the observations of the ISPs indicated that: o All appropriate disciplines were present at one (33%) of the observed ISPs. The individuals' ISP that did not have all appropriate disciplines present included Individual #98, (no occupational therapist, physical therapist, or dietician was present at the ISP), and Individual #259 (the physician was not present). o 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 of the ISPs (100%). o The individual was present at all three (100%) of the ISPs meetings observed.	

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		o The IDT consistently used the Risk Level Guidelines when determining risk levels at all three (100%) of the ISP meetings. o The IDT consistently used supporting clinical data when determining risks levels for one of the ISPs observed (33%). The individuals' IDT that did not consistently use supporting clinical data when determining risk levels included Individual #51, and Individual #259. However, although not consistent, the Monitoring Team did note that there was some overall improvement for this indicator. Compliance scores for this indicator reflect the consistency of the use of supporting clinical data when designating risk levels. o Overall, the risk levels the IDTs designated were appropriate for each category for two of the ISPs observed (67%) based on information and data provided by the IDTs. The individual's IDT that did not consistently designate appropriate risk levels for each risk category was for Individual #51. o There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in two (67%) of the ISP meetings observed. The ISP for Individual #259 did not include adequate and appropriate clinical discussion, especially regarding the issue of pica. o Team disagreements regarding risk levels were noted in none of the ISPs observed. Thus, the Monitoring Team did not observe the process of resolving issues. In evaluating this indicator, when team disagreements are observed, the Monitoring Team evaluates 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. o Based on all three ISPs observed by the Monitoring Team, the ISP facilitator kept the team focused in all of the ISPs meetings observed (100%). Areas for continued focus included time management, since some of the ISPs observed were exceptionally lengthy, increasing team discussions of clinical data regarding risk indicators, and increasing discussions regarding necessary services required for community transitions when determining appropriate future placement options. In addition, other positive observations from the Monitoring Team included: o The feedback from the Residential Coordinator at the ISP meeting for Individual #259 was very valuable regarding a poorly functioning communication device; o All team members respected the comments and observations of the family member for Individual #51. o The IDT facilitators for all three ISPs did a good job in promoting team participation, as well as in preparing materials, and packets. o There was good discussion of preferences, and leisure activities at the ISP for Individual #259. In addition, the QDDP frequently pushed the team to consider alternative ideas during the ISP.	

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		o Although not consistent, there was an increase in the use of specific clinical data to support risk ratings. Problematic areas needing continued focus and improvement included: o The team for Individual #259 had a number of clinical questions regarding the diagnosis of pica, as well as some of the individual's medical issues that the nurse was unable to answer. The absence of the individual's Primary Care Practitioner (PCP) at the ISP meeting left these questions unresolved, and the psychiatrist reported "flying in the dark" due to not having the necessary medical information. o Although there was a great deal of discussion at the IDT for Individual #51 regarding dementia, there was no review of the medical work-up or discussion of the potential causes of the symptoms until prompted by the Monitoring Team. Without this clinical information, appropriate follow-up, and treatments could not accurately be determined. In addition, as an active an ongoing problem, the issue of Dementia should have been listed as a separate risk indicator in the "Other" category with its own set of clinical criteria, and risk rating. o At the ISP for Individual #259, it was unclear why the Speech Language Pathologist presented information from an old assessment, when the QDDP and the nurse had the current assessment. o Regarding action plans related to high and medium risk ratings, overall the IDTs observed had limited and incomplete discussions of action plans related to these risk ratings. In several cases, the objectives were not functional and/or measurable, and adequate preventative measures were not discussed. o In addition, action plans that were discussed in the ISP meetings included inadequate objectives that were not fully discussed by the IDTs in order to establish a measure of success or failure of the action plan, and the interventions did not reflect the clinical intensity commensurate with the level of risk designated by the teams. To further assess the Facility's screening of those with high-risk health concerns, eighteen records were reviewed for integration of risk information into the ISP process and into the ISP document. For three of the 18, the integrated risk rating form or document that provided justification of the risk rating was not submitted. For one active record, the attendance roster for the IDT was not submitted. The following data summaries the information that was available. The denominator varied; for the active records in which this information was not forwarded, that record was not included in the total. ▪ For 14 out of 16 (88%) active records, the appropriate disciplines were present at the ISP meeting. ▪ For eight out of 16 (50%), the individual was present at the ISP meeting.	

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		▪ For 11 out of 15 (73%), the IDT used the Risk Level Guidelines when determining risk levels. ▪ For 14 out of 15 (93%), the IDT used supporting clinical data when determining risk levels. ▪ For 10 out of 15 (67%), the designated risk levels were appropriate for each category (i.e., the team provided adequate justification). With regard to the timely intervention of the IDT in health status change, several ISPAs were submitted that occurred due to an individual's hospitalization. The following ISPAs were reviewed: Individual #226, dated 2/27/12; Individual #226, dated 10/12/11; Individual #312, dated 11/29/11; Individual #136, dated 12/12/11; Individual #6, dated 12/1/11; Individual #43, dated 12/15/11; Individual #41, dated 10/12/11; Individual #41, dated 1/12/12; Individual #281, dated 2/27/12; Individual #281, dated 3/15/12; Individual #74, dated 3/1/12; Individual #23, dated 10/11/11; Individual #211, dated 1/11/12; Individual #237, dated 1/17/12; and Individual #161, dated 2/13/12. Some of these ISPAs demonstrated quality documentation of integrated discussion, and some teams appeared to be aggressive in ensuring the problem that was the focus of the meeting was reviewed to determine if changes were needed. However, changes in risk ratings were not uniformly reviewed. Some simply listed level of risk, but appeared to separate this from the remainder of the discussion as opposed to addressing the level of risk for that concern in the action steps and recommendations made. Others did not mention risk, and others postponed the level of risk for various reasons (e.g., the individual was still in the hospital, there needed to be more information gathered, etc.). The contents of the ISPAs varied, and several included important details regarding which critical steps were then taken to ensure a full recovery after hospitalization. Few discussed measurement tools to determine success of the plan and health of the individual, or when the team should have a follow-up discussion about the actions taken. The QA Department should develop criteria for these post-hospitalization activities to objectively measure the response of the IDT in meeting the needs of the individual. The Facility indicated that it was not in compliance with this provision of the Settlement Agreement. This comports with the findings of the Monitoring Team. From the Monitoring Team's observations and reviews, some progress had been made in the overall increase in the use of supporting clinical data when assessing risk levels, as well as revisions to the structure and format of the ISPs, although these changes were not consistently seen in the documents. Significantly more efforts should be made in constructing the Facility's At-Risk system, including processes aimed at addressing the reassessment of risk factors for individuals experiencing significant changes in status. In addition, LBSSLC also should continue to provide training and mentoring for the IDTs regarding the At-Risk process.	

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I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Based on a review of records for 42 individuals determined to be at risk (i.e., Individual #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, Individual #276, Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #9, Individual #74, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149, Individual #139, Individual #323, Individual #128, Individual #16, Individual #199, Individual #104, and Individual #324), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for seven of these (17%) individuals. For the remaining individuals, there was no indication that all assessments addressing risks issues were timely initiated (Individual #56, Individual #130, Individual #45, Individual #154, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #306, Individual #86, Individual #13, Individual #304, Individual #276, Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #9, Individual #74, Individual #59, Individual #43, Individual #239, Individual #149, Individual #139, Individual #128, Individual #16, Individual #104, and Individual #324). Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include assessment and/or specific clinical data supporting the risk ratings for the health indicators. ▪ No Integrated Risk Rating forms were included in the requested documents for nine individuals (i.e., Individual #13, Individual #304, Individual #306, Individual #45, Individual #281, Individual #174, for Individual #239, Individual #211, and Individual #176). As a result, it was unclear if assessments were needed or not. ▪ An Integrated Risk Rating form for Individual #184 had been completed a year prior to the ISP without being reviewed, and updated. For this individual, it also was not clear if further assessments were needed based on the person's current status. ▪ The IDT members did not meet to re-assess risk levels for individuals who experienced a change in status, such as a visit to the Emergency Room, and/or admission to the hospital for Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #43, Individual #139, Individual #9, Individuals #323, Individual #128, and Individual #324. ▪ For the remaining individuals, no documentation was found indicating that assessments that were to be completed had actually been done.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Nursing Assessments Based on a review of 22 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 #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, and Individual #276. As noted during previous reviews, the Facility continued to use the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment requirement noted in the current At-Risk Individuals policy. However, consistent with the findings from past reviews, these quarterly/annual Comprehensive Nursing Assessments were not adequate to address the health risks of the individuals, and had been completed months prior to or after the meeting determining risk levels without the information being updated in alignment with the team's risk levels. As noted from the Monitoring Team's previous four reviews, a review of the quarterly and/or annual Comprehensive Nursing Assessments for the above 22 individuals found that none of them (0%) contained an adequate assessments of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section. At the time of the review, no specific procedure was in place defining the process regarding nursing assessments for risk indicators. From previous discussions with State Office Consultants, the State was in the process of reviewing, and refining the At-Risk process in an effort to clarify the process, as well as expectations for documentation. However, at the time of the review, no changes had yet been made to the existing at-risk process. Regarding nursing, as noted from previous reviews, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. Medical Assessments Based on a review of 18 records for individuals determined to be at risk (i.e., Individual #52, Individual #276, Individual #204, Individual #6, Individual #203, Individual #74, Individual #34, Individual #23, Individual #17, Individual #111, Individual #113, Individual #269, Individual #143, Individual #298, Individual #324, Individual #315, Individual #198, and Individual #84), it could not be determined whether or not the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk. It is recommended the Facility create a tracking system listing dates of action that follow the identification of individuals at risk.	

#	Provision	Assessment of Status	Compliance
		Based on a review of six individuals' records in response to changes in an at-risk individual's condition (i.e., Individual #111, Individual #113, Individual #74, Individual #203, Individual #6, and Individual #23), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of changes in an at-risk condition for four of six (67%) individuals. Records that did not contain documentation of this requirement included Individual #111 and Individual #203. Based on a review of 18 individual records for whom assessments had been completed to address the individuals' at-risk conditions, 12 (67%) included an adequate medical assessment to assist the team in developing an appropriate plan. As mentioned with regard to Section I.1, for three records, insufficient information was submitted to allow completion of a review. Records that did not contain documentation of this requirement included Individual #17, Individual #113, and Individual #198. There appeared to be no follow-through on plans agreed upon by the team. For instance, for both Individual #17 and Individual #198, a DEXA scan became part of the assessment and plan, but there was no result forwarded or reviewed in the IPN for either of these individuals. Individual #113 might have benefited from a pulmonologist consultation, based on his history of respiratory illness, but this did not appear to have occurred. <u>OT/PT and SLP Assessments</u> Based on a review of 20 individuals' records for which OT/PT assessments were to be completed to address the individuals' risk conditions, four of the 20 individuals' records (20%) (i.e., Individual #176, Individual #74, Individual #78, and Individual #324) included an OT/PT assessment that addressed individuals' risk levels to assist IDT members in completing the Integrated Risk Rating form. Problematic issues that resulted in noncompliance included: ▪ OT/PT assessments did not adequately assess medium and high-risk areas that required services and support from Habilitation Therapies; and ▪ ISP and/or Integrated Risk Rating attendance sheet documentation did not confirm attendance by OTs and PTs to offer their clinical expertise during the interdisciplinary risk assessment process. The Facility should adopt the State-established OT/PT assessment format content guidelines for risk levels to provide consistency in the assessment of risk levels. For example, some assessments simply listed information from the individuals' Integrated Risk Rating form. There was no discussion of the current services and supports for identified risks, rationale and efficacy for services and supports, and individual triggers to alert staff to a change in status. Based on a review of 20 individuals' records for which SLP assessments were to be	

#	Provision	Assessment of Status	Compliance
		completed to address the individuals' at risk conditions, one of the 20 individuals' records (5%) (i.e., Individual #211) included a SLP assessment of risk levels to assist the IDT members in assessing an individual's risk ratings. Problematic issues that resulted in noncompliance included: ▪ SLP assessments were not timely. For example, SLP assessment dates showed that assessments occurred in the 2008 for Individual #149, Individual #233, Individual #59, and Individual #16; ▪ SLP assessments did not adequately assess medium and high-risk areas that required services and support from Habilitation Therapies; and ▪ ISP and/or Integrated Risk Rating attendance sheet documentation did not confirm attendance by SLPs to offer their clinical expertise during the interdisciplinary risk assessment process. As discussed in further detail with regard to Section R, the Director of HT was in the process of updating the Master Communication Plan to prioritize individuals who required an update to their communication assessment for risk levels. The incorporation of the assessment of risk level services and supports into the SLP assessment process should provide relevant information to assist individuals' IDTs in the development of a risk action plan. However, SLP assessments reviewed did not consistently address these risk level revisions. Audits should be conducted to verify OT/PT and SLP assessments follow the State-established content guidelines for risk levels. Furthermore, when an individual has a significant change in status (i.e., hospitalization), the IDT members should begin assessment as soon as possible, or within five working days. 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	Based on a review of 42 records for individuals determined to be at risk (i.e., Individual #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, Individual #276, Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #9, Individual #74, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149, Individual #139, Individual #323, Individual #128, Individual #16, Individual #199, Individual #104, and Individual #324), there was documentation that the Facility:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none of the cases reviewed (0%). Although the Action Plans included a date of implementation, no supporting documentation verified that the action steps contained in the plan had, in fact, been implemented. In addition, a number of the action steps were nonspecific, and thus, impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the 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 28 of the cases (67%). Individuals' ISPs that did not have the plans integrated included: Individual #13, Individual #304, Individual #86, Individual #306, Individual #281, Individual #174, Individual #120,Individual #104, Individual #43, Individual #9, Individual #109, Individual #176, Individual #211, and Individual #239. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. In addition, other problematic issues that resulted in noncompliance with the above compliance indicators included: o Risk Action Plans were not completed or included with the requested documentation by the Monitoring Team for two individuals (i.e., Individual #281, and Individual #174. o Risk Action Plans were generic, and non-specific in addressing the health risks of the individual. o Preventative interventions were not included in any of the Risk Action Plans. o ISPs were not completed or included with the documentation the Monitoring Team requested for three individuals (i.e., Individual #13, Individual #86 and Individual #306).	

#	Provision	Assessment of Status	Compliance
		o The interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency of monitoring. o The interventions listed on the Risk Action Plans were not in alignment with the designated risk rating of high or medium risks. At the time of the review, the Facility indicated it was not in compliance with the requirements of this provision of the Settlement Agreement. This comported with the Monitoring Team's findings. LBSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate risk action plans for each individual. The Risk Action Plans should meet the individuals' needs, contain functional and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

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

1. In prioritizing involvement in the ISP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. (Section I.1)
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The IDTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)
3. 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)
4. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the IDTs. 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)
5. The risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
6. The Facility should consider maintaining formal minutes of the Risk Workgroup meetings. Such minutes should clearly outline the specific information discussed, responsibilities assigned, timeframes for completion of activities/assignments, dates of actual completion of activities/assignments, outcomes, and any further monitoring activities needed to assess outcomes. (Section I.1)
7. Additional training on the at-risk process should be provided to the IDTs. 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)
8. To standardize the team process, one nurse and one behavior analyst should be trained on implementation of the new risk rating process, risk action plan development, and plan implementation process. These staff could then act as mentors for the risk process implementation, and attend as many of the IDT meetings as possible to ensure basic aspects of the new policy and procedure are followed. (Sections I.1, I.2, and I.3)
9. 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)

10. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
11. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
12. When there is a change in health status, the IDT 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 IDT should meet promptly to address any changes in health and functional status. (Sections I.1, I.2, and I.3)
13. 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)
14. 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. (Sections I.1 and I.2)
15. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
16. Given that IDTs, at times, do not realize when more assessment is indicated, department heads should review IDT findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Sections I.1, and I.2)
17. The Facility should create a tracking system listing dates of action that follow the identification of individuals at risk, including the assessment process and the development and implementation of risk action plans. (Sections I.2 and I.3)
18. The Facility should adopt the State-established OT/PT assessment format content guidelines for risk levels. (Section I.2)
19. Audits of OT/PT and SLP assessments should be conducted to ensure therapist compliance with the State-established content guidelines for risk levels. (Section I.2)
20. The absence of OTs, PTs, and SLPs at annual ISP meetings, and at ISPA meetings for individuals who experienced a change in health status did not support an interdisciplinary assessment of an individual's risk levels. To move forward in achieving compliance within this section, therapists should attend annual ISP and ISPA meetings, as appropriate based on the individual's needs. (Section I.2)
21. 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 should reevaluate it, and potentially revise it. (Section I.3)
22. The Facility should monitor the ISPs to ensure the risk ratings and action plans are integrated into individuals' ISPs. (Sections I.1, I.2, and I.3, and Facility Self-Assessment)
23. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Self-Assessment 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. (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**: **Review of Following Documents**: o Agenda and supporting materials from the 3/20/12 Pharmacy and Therapeutics (P&T) Committee Meeting; o Alphabetical list of individuals psychiatrically hospitalized during the last year; o Reiss Screening instrument spreadsheet; o A table entitled: "Comparative 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 Policy for psychiatric services, revised 4/27/11; o Policy for psychiatric assessments, dated 9/1/08, and revised 3/5/12; o Policy for prescribing psychoactive medication, revised 6/8/10; o The following documents that were in the Presentation Book related to Section J of the Settlement Agreement, dated 2/29/12: • The Plan of Improvement/Self-Assessment for the Psychiatry section; • Quality Assurance Monitoring Reports, for the last six months; • Document entitled "Psychiatry – Section J: Progress Since Monitoring Visit;" • Summary and supporting evidence for each of the 15 Provisions of Section J of the Settlement Agreement; 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; o Spreadsheet of Monitoring of Side Effects Scale (MOSES) evaluations completed through January 2012; o Spreadsheet of Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations completed through February 2012; o List of individuals prescribed benzodiazepines; 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 individuals prescribed anticholinergic medication; o List of individuals prescribed intra class polypharmacy;

	○ List of individuals monitored for tardive dyskinesia; ○ List of individuals prescribed an anticonvulsant medication for psychiatric reasons; ○ List of meetings and rounds attended by the psychiatrists, undated; ○ Curriculum vitae (CV) of Richard Weddige, M.D.; ○ CV of Boris Porto, M.D.; ○ CV of Gary Moranville, M.D.; ○ Overview of psychiatrists' weekly schedule, undated; ○ Job description of Psychiatrist III, undated; ○ Minutes, supporting documents and attachments for the "Monthly Facility Review of Psychoactive Medication Polypharmacy" Meetings, for the past six months; ○ Pre-treatment Sedation Checklist for Dental Appointments; ○ Documents related to the 3/22/12 Meeting of the Desensitization Committee; ○ Policy for Dental Desensitization, dated 3/20/11; ○ The following sections of the medical record: Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet); Social History Evaluation; the Individual Support Plan (ISP) 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, including tool and team meeting sheet (only most recent); Psychiatry section, inclusive of the most recent Comprehensive Psychiatric Assessment (CPA); MOSES; DISCUS; Side Effects Screening section; Quarterly Drug Regimen Reviews (QDRRs); 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 #197, Individual #75, Individual #155, Individual #279, Individual #94, Individual #108, Individual #137, Individual #125, Individual #79, and Individual #99; ○ The same set of records was requested for the following individuals who had recently been admitted to LBSSLC: Individual #57, and Individual #31; ○ The same set of records was requested for the following individuals due to their clinical acuity: Individual #239, Individual #51, Individual #33, Individual #7, Individual #92, Individual #131, and Individual #124; and ○ The same set of records was requested for the following individual who had been psychiatrically hospitalized within the last year: Individual #22. ▪ **Interviews with:** ○ Dr. Richard Weddige, Director of Psychiatry, on 3/19/12; ○ John McCullen, Psychiatric Assistant, on 3/19/12 and 3/20/12; ○ James Forbes, Director of Psychology Services, on 3/19/12; ○ Dr. Russell Reddell, Director of Dental Services, on 3/19/12; ○ John Todd, R.PH., Clinical Pharmacist, on 3/19/12;

	○ Glen Shipley, D.O., Medical Director, on 3/19/12; ○ Shelia Powell, Human Rights Officer, on 3/20/12; ○ Dr. Gary Moranville, Locum tenens Psychiatrist, on 3/22/12; and ○ John McCollum, Psychiatric Assistant, Bob Robbins, Program Compliance Monitor, and Dr. Richard Weddige, on 3/22/12. ▪ **Observations of**: ○ Polypharmacy Committee Meeting, on 3/20/12; ○ Morning Provider Meeting, on 3/20/12; ○ Pharmacy & Therapeutics Committee Meeting, on 3/20/12; ○ Human Rights Committee Meeting, on 3/20/12; ○ Psychiatric Clinics, on 3/21/12 and 3/22/12; ○ Neurology Clinic with Dr. Daniel Hurst, on 3/21/12; ○ Desensitization Committee Meeting, on 3/22/12; ○ ISP Meeting for Individual #51, on 3/22/12; ○ During visits to the residential Living Units and Vocational Programs at LBSSLC, the following individuals were observed: Individual #7, Individual #92, Individual #197, Individual #181, Individual #168, Individual #275, Individual #171, Individual #12, Individual #167, Individual #82, Individual #38, Individual #75, Individual #155, Individual #140, Individual #237, Individual #106, Individual #213, Individual #300, Individual #235, Individual #276, Individual #116, Individual #154, Individual #75, Individual #99, Individual #108, Individual #291, Individual #84, Individual #124, Individual #240, Individual #10, Individual #320, Individual #125, Individual #239, Individual #273, Individual #57, Individual #322, Individual #126, Individual #254, Individual #8, Individual #73, Individual #179, Individual #33, Individual #161, Individual #309, Individual #175, Individual #221, Individual #60, Individual #279, Individual #288, Individual #50, Individual #61, Individual #112, and Individual #131.
	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. On 3/22/12, during the onsite review, these materials were reviewed with the Director of Psychiatry, the Psychiatry Assistant, and the Program Compliance Monitor for Psychiatry. 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 and the Program Compliance Monitor assigned to the Psychiatry Department. The Program Compliance Monitor randomly selected a monthly sample of five individuals' records. The Psychiatry Assistant performed a review all five, and the Program Compliance Monitor reviewed three. The Program Compliance Monitor also chose which one of the records would be used for the determination of inter-rater 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/QI 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 assist him in appropriately performing the QA review of an individual's psychiatric record. During the meeting of 3/22/12, the Facility's compliance rating for each provision in Section J of the Settlement Agreement was reviewed. 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 related to differences in the interpretation of the language of the Settlement Agreement, and a focus by the Monitoring Team on the quality of certain items rather than simply ascertaining if the material was present or absent. Some of the variance might also have resulted from simple differences in the composition of the two samples. The following summarizes the similarities and differences, and the potential reasons for the differences: ▪ The Monitoring Team and the Facility's internal QA Team reported similar findings of substantial compliance for Section J.1, which related to the qualifications of the Psychiatrists. There was also agreement for Section J.15, for which both the Monitoring Team and the internal QA Team utilized similar methods, and the Facility had been in compliance on prior reviews. ▪ There was also agreement on a finding of noncompliance for Sections J.2, J.4, J.6, J.8, J.9, J.10, J.12, J.13, and J.14. However, important differences were noteworthy in the methodologies the Monitoring Team and the internal QA Psychiatry Team utilized. For the majority of these sections, the internal team cited the Facility's inability to complete CPAs for all of the individuals receiving psychotropic medication. This was a crucial factor in the determinations of the Monitoring Team for Sections J.2 and J.6. However, many additional factors were utilized in the assessment of the other sections. At the time of the 3/22/12 meeting, this was discussed with the internal review team, because it was apparent that the results of the internal record audits were not being routinely incorporated into the Facility Self-Assessment for many of the sections where this information would have been helpful in guiding the Facility's internal self-improvement process. ▪ The difference in the Facility's self-rating of substantial compliance for Section J.4 and the Monitoring Team's finding of noncompliance was not clear, because the Facility noted in item #3 under "Activities engaged in to conduct the self-assessment:" "Review of Reiss Screens for maladaptive behavior will be completed every two years in conjunction with the individual's psychological assessment." Although this initiative was due to begin soon, it remained to be fully implemented. Thus, this observation would support a finding of noncompliance. ▪ The disparity of the Facility's assessment of substantial compliance for Section J.11 and the Monitoring Team's finding of noncompliance appeared to be due to the Facility's emphasis on the fact that they perform monthly reviews of those individuals receiving polypharmacy, whereas the Monitoring Team also assesses for compliance with the element of this provision that stipulates that absent a reduction plan existing polypharmacy should be "clinically justified." ▪ The similar discrepancy between the two ratings for Section J.12 regarding the monitoring of side effects could be attributed to differences in the sample composition. However, the statistical basis for the LBSSLC self-assessment was not described in the Facility Self-Assessment. ▪ The only other area of disagreement related to Section J.5 (i.e., amount of psychiatry time available). In this case, the Facility found itself in noncompliance and the Monitoring Team rated

	the Facility as in substantial compliance for the reasons described in the discussion of that section below. The rationale for this discrepancy appears to be that the Facility Self-Assessment was prepared before it was clear that the new full-time locum tenens Psychiatrist would likely continue on at the Facility on a long-term basis. In summary, the Psychiatry Department was actively engaged in the process of self-assessment. However, the Facility should include the data obtained from the internal QA sampling of approximately 60 individual records for the year into the overall self-assessment initiative, rather than viewing it as a parallel process.
	Summary of Monitor's Assessment: The Facility had added a new full-time locum tenens Psychiatrist, who might continue as a full-time Staff Psychiatrist. The Director of Psychiatry had performed a time analysis that accounted for activities such as attending the ISP meetings, as well as completing the Comprehensive Psychiatric Assessments, and concluded that two full-time Psychiatrists should be sufficient to provide services to the 126 individuals prescribed psychotropic medication at LBSSLC. This analysis also took into account the support staff, which included a Psychiatric Assistant and a newly added Psychiatric Clerk. The current full-time Psychiatrists were both Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, and the part-time Consulting Psychiatrist, who was on site for four hours per week, was Board Certified in Child Psychiatry by the American Board of Psychiatry and Neurology. The Facility clearly had responded to the recommendations made in the Monitoring Team's previous report. This was evident in the progress in many of the 15 provisions of Section J of the Settlement Agreement. The Psychiatry Department had revised the content of the Comprehensive Psychiatric Assessments to better conform to the requirements of the Settlement Agreement. The Facility reported that these had been completed for over 50 percent of the individuals who received psychotropic medications. With two full-time Psychiatrists, and the Consulting Psychiatrist continuing on four hours per week to assist with the CPAs, it was anticipated that the Facility would complete these within the next six to 12 months, for all of the individuals who receive psychotropic medication, and then maintain the process of annual updates in conjunction with the individuals' ISP reviews. On 3/12/12, a member of the Monitoring Team attended the Desensitization Committee Meeting. Representatives from the Psychiatry, Psychology, Dental, Medicine, and Nursing Departments, as well as the QDDP Educator and others attended this meeting. The discussion was quite detailed, and it was clear that the effort to address Section J.4 was now actively in process. In the Monitoring Team's previous report, problems with the completion of the documents related to the use of pre-treatment sedation were identified. The Psychiatry Department had developed a system to facilitate the timely completion of the various steps in this process, which recently had been implemented. The Facility also had developed a policy to identify individuals who could benefit from a Reiss Screening Assessment, and there was documentation that indicated this new policy was being followed. The

	Psychology Department was launching a previously delayed initiative that would include the administration of the Reiss Screen to the individuals who were not receiving psychotropic medication and who had not been screened in several years. This was to occur in the context of a complete psychological assessment. The Psychiatrists had begun to attend the ISPs, and, now, with the two Psychiatrists available, it should be possible to do this on a regular basis. During the onsite review, a member of the Monitoring Team was able to attend the ISP meeting of an individual and the individual's Psychiatrist was an active participant. The review of the documentation from an earlier ISP that the Psychiatrist had attended indicated that some of the contributions from psychiatry were included under the medical section and others under the psychology section. It will be important that the psychiatric contributions are clearly indicated in the final ISP documentation, including their integration with other disciplines. Another issue related to documentation had been the dual identification of target behaviors of the psychotropic medications, such as aggression or self-injury, as also being present on a learned basis, which gave the impression that the medication was being used to suppress a learned behavior. In many individuals, the behavior was, of course, determined by both factors. The Psychiatry Department had responded to this with thorough discussions in the CPAs and elsewhere in the records, and the Psychology Department had now added a discussion that addressed this in the Functional Analysis. Progress regarding reductions in polypharmacy continued. The Psychiatry Department had created three sub-categories that were derived from comments made in the Monitoring Team's previous reports. The two primary categories were "Active" to denote those individuals that the Department was still making ongoing efforts to decrease one or more of the current psychotropic medications, and "Stable" for those individuals who were felt to require their existing medication to maintain their continued stability. The importance of assembling as much empirical evidence as possible to document the efficacy of these medications, and, thus, justify their continued utilization was discussed during the onsite review with the Psychiatry Department team, and is expanded upon in the report that follows. The Department was considering enlisting the help of their new clerk in assembling this data. The third category, which was labeled: "New Admissions," tracked the progress of the individuals who had been admitted from the community on multiple psychotropic medications. The Monitoring Team was able to follow three of these individuals longitudinally over the past year in the observations of the Psychiatric Clinics, and their progress had been remarkable. In summary, LBSSLC had made progress in a number of areas. This progress, as well as areas that require ongoing attention, are discussed in the report that follows.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services	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	Substantial Compliance

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	only by persons who are qualified professionals.	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 has worked full-time at the Facility for the last ten years. Prior to the previous 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 Adult Psychiatry as well as 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 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 (ID) 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. Within the weeks prior to the current review, the Facility had contracted through a locum tenens agency for the full-time psychiatric services of Dr. Gary Moranville, whose CV indicated that he was Board Certified by the American Board of Psychiatry and Neurology in Adult Psychiatry. On 3/22/12, during the interview with Dr. Moranville, he described two prior periods of employment during which 25% to 30% of his clinical time had been devoted to the provision of psychiatric services to individuals with intellectual disabilities and/or developmental disabilities (ID/DD). The Facility remains in substantial compliance with this provision. The American Board of Psychiatry and Neurology had certified all of the Psychiatrists who provided services to the individuals who resided at LBSSLC.	
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	At LBSSLC, a total of 126 individuals were prescribed psychotropic medication. A sample of individuals was selected for review, as defined in the section above listing the documents reviewed. This included 20 individuals, or 16% of those prescribed psychotropic medication. As noted above, at the time of the review, the Psychiatrists who diagnosed and treated	Noncompliance

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	having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	the individuals who resided at LBSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The Psychiatrists had extensive amounts of prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. Although the psychiatric diagnoses appeared in a number of sections of the individuals' records, the clinical justification that supported the validity of the diagnosis primarily appeared in the related sections of the CPAs, the Quarterly Psychiatric Reviews, and the "Psychiatric Consultation – Diagnostic and Treatment Analysis." As noted in the prior reports, the Facility had begun an initiative to complete a thorough CPA that would comply with the terms of the Settlement Agreement for all of the individuals who were receiving psychotropic medication. The Department of Psychiatry maintained data related to its progress in completing the CPAs for those individuals who received psychotropic medication. Review of this document entitled: "Psychiatric Assessments (Active List)," which was dated 2/23/12, indicated that, since the initiative had begun, a total of 97 "Revised Comprehensive Psychiatric Assessments" had been completed. This would represent 77 percent of the 126 of the individuals receiving psychotropic medication, which was higher than the 43 percent completion rate (54 of 126) reported in the Facility's Self-Assessment of 1/25/12. Thus, the 3/23/12 list might have represented some CPAs that were still in the process of being revised. The review of the records of 20 individuals who were receiving psychotropic medication indicated that 18 contained a CPA that had been completed within the last 12 months and met the content and quality standards set forth in the Settlement Agreement (90%). The two exceptions were the record for Individual #155, which was missing significant amounts of information in both the Psychology and Psychiatry sections of the record, and Individual #51 for whom the diagnosis that was contained in the CPA, as well as elsewhere in the record, was different from the diagnosis discussed at the Individual's ISP meeting on 3/22/12. This is also discussed with regard to Section J.13 The review of these documents indicated that all of them complied with the specifications of the Settlement Agreement. The diagnostic sections of the records provided a thorough description of the symptoms that supported the psychiatric diagnosis. However, the 90 percent completion rate is significantly higher than the corresponding rate of actual completion for the larger population of individuals receiving psychotropic medication. This relates to the composition of the review sample, which included individual records the Facility selected, newly admitted individuals, and individuals who had a high level of psychiatric acuity. The revised CPAs that met the standards specified in the SA had all been completed within the past year.	

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		The quality of the individuals' psychiatric diagnosis is also discussed with regard to Section J.13. That review indicated that the psychiatric diagnosis for 18 of the 20 individuals (90%) in the sample of 20 individuals who were receiving psychotropic medication contained adequate documentation to justify the individuals' psychiatric diagnosis. The specific details of this review are discussed with regard to Section J.13. In summary, the quality of the more recent CPAs clearly met the standards set forth in the Settlement Agreement. The finding of noncompliance for this section relates to the Facility's current inability to complete these evaluations for a sufficient number of the individuals who were prescribed psychotropic medication at LBSSLC. However, the Psychiatry Department was making significant progress in completing these important documents for the individuals at LBSSLC who receive psychotropic medication, and at the current rate of completion these likely would be completed for all of the individuals receiving psychotropic medication in the coming months.	
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.	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatry Clinics, as well as the review of the records of 20 individuals who were receiving psychotropic medication, did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication is discussed with regard to Sections J.2 and J.13. The 20 records that were reviewed indicated that there was an active PBSP for each individual who was prescribed psychotropic medication. However, for six of the 20 individuals (30%), the behaviors that were identified as the "target behaviors" of the psychotropic medication also were identified in the Functional Analysis and related Positive Behavior Support Plan (PBSP) as being present on a behavioral basis and/or related to environmental factors. This finding will be discussed in greater detail below with regard to Section J.9 of the Settlement Agreement. This observation suggested that for these individuals, the prescribed psychotropic medication could be construed as having been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this provision of the Settlement Agreement. In other words, they potentially were being used in the absence of adequate behavioral treatments or interventions, which could be construed as being "for the convenience of staff," who were not equipped to respond with the appropriate behavioral interventions. In addition, concerns related to the quality of PBSPs are discussed with regard to Section K.9 of the Settlement Agreement.	Noncompliance

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		As discussed in the Monitoring Team's previous report, the use of chemical restraint also could be construed as punishment, because it frequently involved the oral or intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint was extremely important in differentiating between the necessary uses of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further investigate the use of chemical restraint at LBSSLC, the following sample of chemical restraint data was reviewed:	

INDIVIDUAL #	DATE	TIME	MEDICATION
Individual #213	1/30/12	8:31 a.m.	Ativan 2 milligrams (mg) (route of administration not specified)
Individual #33	2/17/12	10:15 p.m.	Ativan 2mg IM
Individual #299	2/29/12	6:00 p.m.	Haldol 5mg; Ativan 2mg (route of administration not specified)
Individual #25	3/1/12	9:42 a.m.	Ativan 1mg (route of administration not specified)
Individual #288	3/5/12	6:33 p.m.	Ativan 2mg IM

The individual restraint data was reviewed for the presence and quality of the six components of the documentation that the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections and the results of this review are as follows:

1. The information contained in the section of the documentation following the prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. This section of the documentation was completed for all five of these individuals. However, the documentation for Individual #288 indicated that this individual had episodes that necessitated restraint earlier in the day, and not the specific "events" or behaviors that precipitated this restraint. The corresponding documentation for four of the five individuals (80%) adequately described the antecedent events.
2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" also was reviewed. This section was completed for all of the individuals, but there was insufficient detail to determine what other interventions had been attempted for Individual #33 and Individual #288. Thus, the documentation was completed adequately for three individuals (60%).
3. The portion of the documentation in which the physiological post-restraint

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		monitoring was recorded was completed for all of the individuals in this sample (100%). 4. The face-to-face post-restraint debriefing was completed for all five individuals (100%). 5. The Facility had developed a form entitled: "The Administration of Chemical Restraint Consult." This document addressed a number of key steps regarding the administration of the chemical restraint process, but was completed for only one individual (20%) (i.e., Individual #213). 6. The Chemical Restraint Clinical Review Form was completed for all five of these individuals (100%). Thus, these essential elements of the documentation needed to verify the appropriate utilization of chemical restraint were fully completed for only one of the five individuals (20%) in this sample. As is discussed in further detail with regard to Section J.9, the Facility had made substantial progress with regard to the differentiation of maladaptive behaviors that were derived from a psychiatric disorder, as opposed to being related to environmental and/or behavioral factors. This was important to ensure that medication was not used as a substitute for adequate programming or for the convenience of staff. However, more work in this area was needed. As noted above, the chemical restraint documentation was deficient in many areas. However, the Facility had made substantial progress in the extremely important area that prompts the staff members working with the individual to "Describe events leading to behavior that resulted in restraint." Previously, these were often found to simply describe the individual's overt behavior that precipitated the behavior, primarily aggression, making it difficult to know if the chemical restraint simply was being used to punish the individual for this behavior. The current sample of records contained more descriptive information concerning the events that led up to the point where the individual's behavior necessitated restraint, rather than simply describing the overt problematic behavior that precipitated the need to utilize chemical restraint. The only individual, for whom this detail was not present in this sample of five recent administrations of chemical restraint, was that of Individual #288 for whom this section only indicated that there had been prior incidents of restraint earlier that day. The Facility remains in noncompliance with this provision due to the ongoing deficiencies in the dual classification of behavior as being both targets of the psychotropic medication and present on a learned basis, and the aforementioned deficiencies in the documentation of the chemical restraint process.	
J4	Commencing within six months of the Effective Date hereof and with	The Human Rights Officer maintained a comprehensive database, in the form of a spreadsheet, concerning the use of pre-treatment sedation. This document listed all	Noncompliance

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	full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	individuals 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. The categories of intervention listed on this spreadsheet were "Dental Restraint, "Dental Sedation," and "Medical Sedation." Sub-categories also were listed for "General Anesthesia" and "IV-Sedation." The total number of individuals listed on this spreadsheet was 125 of the total census of 220 individuals (57%). Of these 125 individuals, 40 required only oral pre-treatment sedation for dental procedures. Within the group requiring sedation for dental procedures, 73 had consents for IV and/or general anesthesia. Pre-treatment sedation for medical procedures was required for 33 individuals. Only five individuals were listed who required pre-treatment sedation for medical procedures and not also for dental procedures. The total of these numbers (151) exceeded 125 due to several individuals who required consent for more than one type of procedure. For example, 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, because 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 1mg to 3mg. Seven individuals received Zydis (a rapidly dissolving sublingual form of the antipsychotic agent Zyprexa) in the range of 5mg to 15mg. 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. On 2/3/12, the Psychiatry Department began tracking individuals who received pre-treatment sedation medication for medical and dental procedures. The spreadsheet listed the individual by name, date of administration, type of pre-treatment sedation medication (medical or dental), specifics of the medication, and a summary of plans to minimize the use of pre-treatment medication. This should provide valuable information in the future. Despite the relatively high number of individuals contained on the aforementioned spreadsheet, which the Human Rights Officer maintained, a relatively small number of individuals actually received pre-treatment sedation in any given month. For example, a request for the documentation related to the administration of pre-treatment sedation medication indicated that since June 2011, only eight individuals had been given pre-	

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		treatment sedation medication. The "Pre-Sedation Assessment" (sic) was a detailed five-page form with a cover page. It included an outline of a seven-step process, which extended from the administration of the medication, to the Incident Management Team's final review, and a sign-off from the staff member responsible for each item. The purpose of this documentation was to ensure that all of the information that the Facility considered to be relevant to the appropriate monitoring for the administration of pre-treatment sedation had been completed as specified, and also that the person responsible for each portion of the documentation had signed their respective section in a timely manner. The Monitoring Team's previous report identified significant deficits in the uniform completion of this documentation. The Psychiatry Department recently had assumed the responsibility for ensuring that these forms were fully completed in a timely manner. A review of the most recent five instances of the administration of pre-treatment sedation medication revealed the following results: ▪ On 1/18/12, Individual #115 received pre-treatment sedation medication for a bone density examination. Review of the related information indicated that all of the relevant sections were completed and signed by the Psychiatrist, Pharmacist, Medical Provider, and Medical Director in a timely manner. Only the signature of the Dentist on the final review page was missing. ▪ Individual #284 received pre-treatment sedation medication for an unspecified procedure. Many sections of the documentation were left blank, as well as the signature page. ▪ On 1/13/12, Individual #264 was administered pre-treatment sedation medication for an unspecified procedure, and many sections of the documentation were left blank, including the signature page. ▪ On 12/9/11, Individual #170 received pre-treatment sedation medication for a bone density scan. The relevant sections were completed, and the signatures of the Psychiatrist, Pharmacist, Medical Provider, and Medical Director were present. Only the signature of the Dentist was missing on the final review page. ▪ On 12/9/11, Individual #119 received pre-treatment sedation medication for a mammogram. Post-procedure physiological monitoring was present, but other sections of the necessary information (Narrative Notes and signatures) were missing. These five most recent packets of information related to the use of pre-treatment sedation continued to contain significant omissions. The Psychiatry Department only recently had assumed responsibility for ensuring that these documents were completed according to the Facility's specifications, and their progress will be assessed in future	

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		reviews. It is not entirely clear why there was a signature line for the Dentist to sign off on those episodes of pre-treatment sedation that were related solely to medical procedures, and that might explain why this signature was missing in the records described above. However there did not appear to be an explicit explanation for the absence of this signature in the documents that were reviewed. With regard to desensitization or other strategies to reduce the need for medication, at the time of the Monitoring Team's previous review, the Facility had created a prioritized 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, as of that review. At that time, a similar request for data related to Medical Desensitization Plans indicated that none had been developed. During interviews with the Psychiatry Department, the Director of Behavioral Services, and the Director of Dental Services, LBSSLC's progress in this regard was discussed. On 3/22/12, a member of the Monitoring Team also attended the meeting of the Dental Desensitization Committee. The Director of Psychiatry, Director of Behavioral Services, representatives from Medicine and Nursing, the Human Rights Officer, the QDDP Coordinator, QDDP Educator, and the Director of Residential Services attended this meeting, which the Director of Dental Services chaired. This meeting, which representatives of a number of relevant professionals attended, was devoted to solving both practical and procedural problems related to the full implementation of Behavioral Desensitization Plans for individuals who could benefit from these interventions for both medical and dental procedures. Data presented at that meeting indicated that 110 individuals had been identified as candidates for Desensitization Plans for dental procedures, and that Plans had been written for 32 of these individuals, and were in various stages of implementation. Twenty-four individuals had been identified as candidates for Desensitization Plans for medical procedures, and the corresponding Plans had been written for eight of these individuals. Thus, although the Facility had begun to make progress in meeting the requirements of this provision of the Settlement Agreement, the Facility remained in noncompliance. In addition to desensitization plans or other strategies to reduce to the extent possible the use of medication being in the initial stages of development and implementation, problems continued to exist with regard to the monitoring and assessment of individuals to whom pre-treatment sedation was administered. Also, the coordination between the disciplines with regard to decisions related to the medications prescribed were not documented, so could not be reviewed to determine their adequacy.	

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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.	As indicated in the comments concerning Section J.1 of the Settlement Agreement, at the time of the review, LBSSLC employed two full-time Psychiatrists. A total of 126 individuals were receiving psychotropic medication. Thus, if the caseloads were divided equally, each of the full-time Psychiatrists would be responsible for the psychiatric care of 63 individuals. The Facility continued to employ the part-time Psychiatrist that had been added for four hours per week prior to the Monitoring Team's previous review. This Psychiatrist did not have an active caseload of individuals, but rather, his time was devoted to performing second-opinion consultations, and completing CPAs. In addition to the Staff Psychiatrists, the Facility also employed one full-time Psychiatric Assistant to help coordinate the psychiatric care of the 126 individuals prescribed psychotropic medication. The Facility also recently added a full-time Psychiatric Clerk to assist with the data collection related to meeting the requirements of the Settlement Agreement. Thus, the total composition of the Psychiatry Department at LBSSLC would appear to have sufficient resources to meet this requirement of the Settlement Agreement, under normal operating conditions. The Director of Psychiatry had completed an analysis of the time commitment required of the Psychiatry Department to both provide ongoing, routine psychiatric services to the individuals at LBSSLC, and fulfill the requirements of the Settlement Agreement. A discussion of these calculations with the Director of Psychiatry indicated that he had taken into account the time needed to prepare and complete the CPEs, attend the ISP meetings of the individuals prescribed psychotropic medication, and other activities required by the Settlement Agreement, as well as maintain the ongoing day-to-day psychiatric treatment of these individuals. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement. It employed a sufficient number of skilled Psychiatrists to provide appropriate clinical services to the individuals at LBSSLC.	Substantial Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated above, the Facility had developed an initiative to complete a thorough CPA for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The review of the medical records of 20 individuals receiving psychotropic medication identified a recently completed CPA for 18 of the 20 individuals in the sample, which also met the formatting requirements specified in the Settlement Agreement (90%). The revised CPAs that met the necessary requirements had been completed within the last year. There was no CPA present in the record of Individual #155, and as noted with regard to Section J.2, there was discrepancy between the diagnosis discussed at the ISP meeting for Individual # 51 and the diagnosis that appeared in the CPA. A current challenge for the Facility was to complete these CPAs in a timely manner. To date, they had not been able to complete these revised	Noncompliance

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		documents for many of the individuals prescribed psychotropic medication. Data regarding the Facility's progress in completing the CPAs is discussed in further detail above with regard to Section J.2. The finding of noncompliance for this provision of the Settlement Agreement related to the observation that the Facility had not been able to complete the CPAs for many of the individuals prescribed psychotropic medication. However, as noted with regard to Section J.2, they were making progress.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss Screen was designed to identify individuals for whom a formal psychiatric assessment should be considered, based on the results. It was not intended to replace a formal psychiatric assessment. The individuals who were prescribed psychotropic medication should have received a CPA, as specified in the Settlement Agreement (as discussed with regard to Section J.2 and Section J.6). Thus, the Reiss Screen should have been administered to those individuals who did not receive psychotropic medication. The spreadsheet, revised on 3/15/12, entitled: "Reiss Screen for Maladaptive Behaviors" listed individuals for whom the Reiss Screen had been administered beginning in 2008, and virtually all of the individuals listed had been screened during the 2008 to 2009 time period. The most recent Reiss evaluations entered on that spreadsheet were for Individual #73, dated 11/9/11; and Individual #203, dated 11/14/11. During the onsite review, the Monitoring Team made an initial request 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. For each of the three prior reviews, the Monitoring Team requested a sample of 20 percent of the Reiss screening assessments listed on 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 on the spreadsheet. Accordingly, a similar review was not completed in conjunction with this review. At the time of previous reviews, 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 prior review, the Director of Behavioral Services indicated that this initiative had not been implemented as planned, due to personnel shortages within the Psychology Department, which necessitated the	Substantial Compliance

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		redeployment of the designated staff members to a clinical caseload. Thus, the Reiss Screens that were first administered in the 2008 to 2009 timeframe had not been updated. As noted above, this Settlement Agreement provision required the administration of the Reiss Screen for newly admitted individuals not receiving psychotropic medication. Other circumstances that 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 prior review, a member of the Monitoring Team discussed these potential occurrences with the Director of Psychiatry, as situations that should prompt the use of the Reiss Screen and possibly a CPA, depending on the results of the Reiss. The Facility had acted on those recommendations and had added the following language to the LBSSLC psychiatric assessment policy, which was revised on 3/5/12." *"1. ASSESSMENT* *A. Persons served admitted to the facility who are prescribed psychoactive medication will receive a psychiatric assessment within two months of admission.* *B. Persons served who develop increased behavioral symptoms and may require pharmacological treatment in addition to a behavior support plan will receive a Reiss Screen for Maladaptive Behavior and possibly a psychiatric assessment depending on the results.* *C. Persons served who are screened with the Reiss Screen for Maladaptive Behavior who demonstrate several symptoms of a possible psychiatric disorder will receive a psychiatric assessment."* On 11/14/11, the information contained in the Presentation Book indicated that a Reiss Screen had been performed on Individual #203. The Reiss Screen results were not formally scored, but the Psychiatry Department reviewed them clinically. Administration of the Reiss Screen had been prompted by an increase in impulsivity, aggression, and disturbed sleep. Following the administration of the Reiss Screen, the Psychiatry Department actively followed Individual #203, and on 12/19/11, the individual had begun a trial of Seroquel. A CPA, which met the criteria set forth in the Settlement Agreement, was completed on 1/6/12, and the Psychiatry Department continued to follow Individual #203. On 11/9/11, Individual #73 was administered the Reiss Screen. The Reiss Screen was administered due to a change in the individual's behavior presentation, and a weight loss. On 12/2/11, a CPA, which met the criteria of the Settlement Agreement, was performed.	

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		The history contained in this document indicated that this individual had been diagnosed with "Personality Change due to medication condition (leukoencephalopathy from acute lymphocytic leukemia) and profound mental retardation." The individual's history and the recent events that led to the Reiss Screen and CPA were discussed. The Psychiatry Department continued to follow the individual. This information indicated the Facility had implemented a policy to address the need for the administration of the Reiss Screen to individuals with a change in their clinical status that could be related to psychiatric factors. The available data indicated LBSSLC had begun to implement this policy with both the administration of the Reiss Screen, and the completion of a CPA meeting the criteria of the Settlement Agreement in a timely manner. Based on interview with staff, the Facility was planning on implementing a previously delayed plan to reassess the psychological status of the individuals at LBSSLC, including those individuals not receiving psychotropic medication. This assessment will include a re-administration of the Reiss Screening instrument for those individuals who had not been evaluated since the 2008 to 2009 time period. At the time of the onsite review, the Facility did not use either the commercially available or the manual scoring methods for the Reiss. The clinical review of the results had been adequate for the utilization of the Reiss Screen to assess individuals with a change in status. However, when it is used for screening large numbers of individuals, a formal method of scoring will need to be utilized. A finding of substantial compliance has been made due to the completion of Reiss screens for relevant individuals, documentation that the Reiss screen was being utilized when an individual experienced a relevant change in status, and as a result of the information obtained through the Reiss screening process, the performance of CPAs that met the standards outlined in the Settlement Agreement.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The integration between Psychiatry and Psychology Services was apparent in the interviews with the two Psychiatrists, as well as the interview with the Director of Psychology Services. These interactions also were visible in the observation of the Psychiatry Clinics of each of the two Psychiatrists, where it was apparent that the Staff Psychologist had a central role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The data was available in both tabular and graphic formats and was discussed during the course of the meeting. There was also a discussion of interpersonal and environmental	Noncompliance

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		factors that might be effecting the individual's presentation. Where appropriate, a member of the nursing staff would comment on any recent medical issues that might be having an effect on the individual's presentation. There was also an attempt to review the efficacy of the prescribed medications with a view toward challenging medications for which there was any doubt about their continued necessity. The observations of the Psychiatry Clinics and the related documents illustrated the active collaboration between the two disciplines. A persistent deficit in this collaboration, in terms of case formulation, had been the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Analysis and the PBSP. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. Developing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, would provide a mechanism to address this problem. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. The discussion in provision J.9 also describes the considerable progress that the Psychiatry and Psychology Departments had made in rectifying these problems. The primary disciplines that attended the Psychiatry Clinics were nursing, psychiatry, psychology, direct support professionals, and the QDDP. Disciplines such as Occupational Therapy and Physical Therapy were, of course, not able to attend the Psychiatry Clinics, because several were held every week. However, these disciplines often did attend the individual ISP meetings. The Psychiatrists also had begun to attend these meetings. The attendance at these meetings, as well as the content, was reviewed for the 20 individuals in this sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP Meeting for six of the 20 individuals (30%). The specific records that contained this documentation were those of: Individual #155, Individual #279, Individual #94, Individual #31, and Individual #22. The record of Individual #51 did not contain this information. However, on 3/22/12, a member of the Monitoring Team attended this individual's most recent review, and directly observed the Psychiatrist's attendance and participation in the ISP process. Although the Psychiatry Department had begun an initiative to attend the individual ISP meetings, the documentation from these meetings did not fully reflect the psychiatric aspects of the individuals' treatment in the majority of the individual records reviewed. The psychiatric aspects were described in two of the records (i.e., Individual #97 and Individual #7). However the description of these contributions were not adequate for any of these individuals (0%). In those individual records that contained this information, there was a discussion of the psychological treatment plan and reference to	

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		the individuals' psychotropic medication. However, no information was included that reflected the psychiatric aspects of their presentation, nor was any mention made of the contributions to the meeting that the member of the Psychiatry Department made. Moreover, action plans did not describe the psychiatric treatment plan or the roles and responsibilities of various staff in the collection and monitoring of data necessary for decision-making related to the treatment plan. Integration of psychiatric supports with other supports was not evident in the individuals' ISPs. During the onsite review, a member of the Monitoring Team suggested the possibility of adding a separate, brief subsection to the ISP documentation to specifically discuss the psychiatric aspects of the individual's care, as well the contribution of the Psychiatrist, if they were present. In addition, the psychiatric treatment plan should be integrated with other treatments, and reflected in the ISP action plans. The Facility remained out of compliance with this provision. Although a member of the Psychiatry Department had begun to attend the individual PSP meetings, this still had not been accomplished on a regular basis for the majority of individuals who were prescribed psychotropic medication. In addition, although progress was being made, a persistent deficit in terms of case formulation was the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Analysis and the PBSP.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as to a certain extent in the documentation found in the sample of 20 records of individuals prescribed psychotropic medication. When making decisions about potential changes in an individual's psychotropic medication, the Psychiatrist relied heavily upon the data related to the frequency of those behaviors that had been identified as the target behaviors of the prescribed psychotropic medication. A significant deficiency in this process related to the degree to which behaviors that were identified as being targets of a psychotropic medication also were identified in the Functional Analysis and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. The review of the sample of the records of 20 individuals receiving psychotropic	Noncompliance

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	pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	medication identified six individuals (30%) for whom the dual classification of behaviors described above was present. The individuals' records that were identified as containing this dual reference to maladaptive behaviors were those of: Individual #75, Individual #99, Individual #57, Individual #31, Individual #22, and Individual #33. For these six individuals, there was a discussion of the derivation of the monitored behaviors in the psychiatric section of the record, which primarily linked these behaviors to the underlying psychiatric diagnosis. Whereas the psychology sections of the record, such as the PBSP and the Functional Analysis, attributed their origin primarily to behavioral and or environmental factors. As will be discussed in more detail below, the Psychology Department had instituted measures to address this problem. The records of the following 13 individuals (65%) contained an adequate differentiation of the behaviors that were present due to biological factors, as opposed to behavioral determinants: Individual #197, Individual #279, Individual #94, Individual #108, Individual #137, Individual #125, Individual #79, Individual #124, Individual #131, Individual #239, Individual #92, Individual #51, and Individual #7. The record of Individual #155 was missing several sections of the record, including those sections of the Psychology and Psychiatry documentation that would be required to address this question. The differentiation of the maladaptive behaviors that the individual presented with was related directly to the concluding requirement in this provision, which addressed "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors, which were (in reality) related to behavioral/ environmental factors, as being linked to a psychiatric disorder would increase the risk that the individual would be prescribed psychotropic medication that was not necessary and, in addition, would not receive the behavioral supports appropriate to address the problem. The Psychology Department had added the "Psychiatric Consultation – Diagnostic and Treatment Analysis" document. It contained more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored target behaviors. The newly formatted CPAs also contained a more detailed discussion of this topic in the sub-heading "Bio-Psycho-Social-Spiritual." While this information addressed this provision, there continued to be a deficit with regard to the extent to which this information was incorporated into the psychological sections of the record, such as the PBSP. However, there had been significant improvement in this regard. During the meeting with the Director of Psychology, he indicated that a new section had been added to the Behavioral Functional Analysis format to specifically discuss this issue.	

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		This addition should further enhance the Facility's progress in this area. LBSSLC was not in compliance with this section of the Settlement Agreement, due to the continuing deficits described above. In addition to the continued problem with the dual classification of behaviors described above, there was insufficient discussion in the ISPs of the teams' deliberations with regard to whether the use of medications represented the least intrusive approach to address the individuals' target behaviors. As discussed with regard to Section J.8, the ISP documentation also will need to contain much more detailed descriptions of the rationale for the use of psychotropic medications and the considerations that went into those decisions.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. Prior reviews of these sections of the records indicated that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors that were identified as the targets of the psychotropic medication. Previously, the discussion of these factors primarily occurred in the Human Rights Committee section of the record, as well as the PBSP. However, additional discussions of this subject had been added in the Bio-Psycho-Social-Spiritual sub-section of the CPA, and a relatively newly developed document entitled "Psychiatric Consultation – Diagnostic and Treatment Analysis," which contained a specific sub-section on "Risk vs. Benefit." This information was not yet fully reflected in the other sections of the individuals' records that discussed the risk-versus-benefit analysis. For example, this detailed analysis was not replicated in the materials that were provided to the guardian for consent, and did not appear in the ISP documentation. The current review found that there was an adequate discussion of the risk-versus-benefit analysis in eight of the 20 individual records contained in the review sample (40%). For these eight individuals, the documentation included a discussion of both the potential and realized side effects of the medication, as well the benefits. In those situations where the individual was already receiving the medication, the actual benefits were described, and if the medication had not been started and/or the effects had not yet been realized, the expected benefits were discussed. (There is further discussion of this process with regard to Section J.14 below). A member of the Monitoring Team was able to attend the 3/20/12 meeting of the HRC and also interview the HRC Officer. The reviews that were performed at the meeting were very detailed, and there were instances that involved the HRC rejecting behavioral plans that had been submitted because of insufficient information. However, in general, the documentation found in the individuals' records did not reflect the degree of	Noncompliance

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		diligence that was observed at the 3/20/12 meeting. The Facility might want to consider strategies that would document the degree of thoughtfulness that goes into these reviews, while still being time efficient. A challenge for the Psychiatry Department will be to complete the risk-versus-benefit analysis for individuals for whom this analysis has not been completed, and further, to facilitate the incorporation of this valuable information into the other sections of the individuals' records that rely on these formulations. The continued existence of a number of individuals who are receiving multiple psychotropic medications further complicated the risk-versus-benefit process, because it becomes more difficult to substantiate the efficacy of multiple medications, and the assessment of risk related to side effects is complicated by medication interactions. Thus, as further progress is made in reducing polypharmacy, this will also have a positive effect on the risk-versus-benefit analysis process. (This is discussed further with regard to Section J.11.) Although the Facility had made progress in reforming the risk-versus-benefit assessment process, the LBSSLC remained out of compliance with this provision.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. LBSSLC had maintained tabular data that illustrated the yearly reductions in the rates of polypharmacy, dating back to 2005. This data clearly illustrated a consistent, marked reduction in the rates of polypharmacy. The current version of this document illustrated additional progress in reducing the frequency of polypharmacy with psychotropic medication. The number of individuals 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 zero to two since that time, with the current frequency of two. 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 2005, to a range of three to seven since that time, with the current frequency of five. The corresponding data for the individuals who received three psychotropic medications indicated a decline from 44 in 6/05, when monitoring began, to 15 in 2/11, and was maintained at 18, as of 8/11 and 2/12. The number of individuals who received two psychotropic medications (54 in 2/12) was in the same range as the prior five reporting periods (53 in 3/09, 56 in 9/09, 56 in 9/10, 62 in 2/11, and 57 in 8/11). 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, 40 in 8/11, and currently 39 in 2/12. 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 seven reporting periods, including 2/12.	Noncompliance

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		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, which was consistent with the prior 8/11 review. The number of individuals receiving two antidepressants also had gradually declined from six in 6/05, to zero in 9/10. The frequency had been maintained at one in the last three reviews. It should be noted that the sum of the numbers of individuals described in the discussion of the subcategories of polypharmacy exceeded the total number of individuals identified as being prescribed medication regimens that constituted polypharmacy. This was due to the fact that those individuals who are prescribed both three or more psychotropic medications and two medications from the same class (intra-class polypharmacy) were only counted once, because both of these conditions meet the criteria for polypharmacy. 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 prescribed 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. The new Psychiatry Clerk also had begun to attend these meetings. On 3/20/12, a member of the Monitoring Team attended the Polypharmacy Committee Meeting. 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 recently admitted to the Facility, after a number of failed community placements and numerous psychiatric hospitalizations, had been prescribed eight psychotropic medications at the time of admission. Since the individual's admission, these medications recently had been decreased to four.	

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		As part of the Monitoring Team's previous reviews, a recommendation was made to consider tracking polypharmacy related to the newly admitted individuals in a separate category. This was due to the fact 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 separately for one year. At each monthly meeting of the Polypharmacy Committee, the progress in simplifying these complicated medication regimens was reviewed During the Monitoring Team's previous review, the Facility reported that the Psychiatry team believed the current medications were justified for a number of individuals, and without them, the individuals' psychiatric status would significantly deteriorate. The terminology contained in this provision clearly indicates that medication regimens meeting the criteria of polypharmacy can be maintained if there is 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 Settlement Agreement. The Facility had responded to this recommendation by developing three sub-categories, which were defined as "Active" to describe those individuals for whom active attempts were still being made to decrease one or more of their psychotropic medications, and "Stable" to refer to those individuals for whom it was believed the medications were necessary to maintain their continued psychiatric stability. The third category was the aforementioned group of individuals who had been admitted from the community on multiple psychotropic medications. At the 3/20/12 Polypharmacy Committee Meeting, the data presented was organized according to the aforementioned three categories. Detailed information was presented for each individual, including the current psychotropic medications, the psychiatric diagnosis, a summary of their clinical status, the rationale for the existing medications, and the plans for any future reductions in these medications. This detailed information was both discussed at the meeting and contained in the minutes of the meeting. The category of active polypharmacy contained this information for the 13 individuals (10%) of the total 126 individuals receiving psychotropic medications. Four individuals were listed within the category of "New Admissions" (3% of the 126 individuals who receive psychotropic medication.) The third category labeled "Stable Polypharmacy – Clinical Justification" contained the same basic information as in the other summaries, as well as an additional section	

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		entitled "Clinical Justification." This section reviewed the historical and current clinical status of 16 individuals (13% of the 126 individuals receiving psychotropic medications), who the Facility believed met these criteria. Accordingly, a member of the Monitoring Team performed a detailed review of the evidence that was presented for these 16 individuals. Based on this review, the type of empirical data required to substantiate clinical efficacy was present for the following six individuals: Individual #82, Individual #34, Individual #94, Individual #140, Individual #58, and Individual #315. The data that was presented in the justification for these individuals included historical and current empirical data that justified the efficacy of the psychotropic medication. However, this information did not focus on the efficacy of each of the multiple medications, and in general presented data that appeared to consider all of the medications as one intervention. This aggregate view of multiple medications representing one single intervention would not be acceptable as a definitive justification for the use of these medications. Nevertheless, the data presented for these individuals was empirical in nature and provided the type of historical context necessary to justify a medication's contemporary effectiveness if each medication had been considered as a separate entity. The data presented for the other 10 individuals in this category tended to be subjective and impressionistic in nature. It is likely that these subjective impressions were predicated on historical clinical observations that could have been empirically substantiated with additional data from the historical data not maintained in the individual's current record, but present in the archival history. This issue was discussed in detail with the members of the Psychiatry Department, and also has been discussed in the Monitoring Team's previous reports. During the onsite review, the Director of Psychiatry indicated that the Department planned on enlisting the newly added Psychiatric Clerk to assist in the historical research that would provide the data necessary to justify an individual's current psychotropic medication. The Facility remained out of compliance with this provision due to the continuing number of individuals who received multiple psychotropic medications whose efficacy had not been empirically demonstrated. However, as noted above, the Facility had made significant progress in both reducing the frequency of polypharmacy and providing clinical justification for those individuals who required multiple psychotropic medications to maintain their continued stability.	
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	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this was also the latency between the time that the Nurse or Psychiatry Assistant completed the exam and the documentation was reviewed and signed by the prescribing practitioner.	Noncompliance

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	psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The Director of Psychiatry indicated that the nursing staff performed the MOSES evaluations, and the Psychiatry Assistant performed the DISCUS examinations. Prior reports indicated that the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination. The review of the sample of the records of 20 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all but the following four individuals (followed by most recent MOSES completion date): Individual #22 (no MOSES in record), Individual #94 (1/9/12 missing second page signature; no prior MOSES in record), Individual #57 (10/25/11 second page missing; no prior MOSES in record); and Individual #279 (1/12/12, 7/14/11, and 1/24/11 second pages missing). Thus, documentation that the MOSES was completed on schedule was present for 16 of the 20 individuals (80%). The records of the 20 individuals contained documentation that the prescribing practitioner had reviewed the MOSES evaluation in a timely manner for all but six individuals. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were the four individuals described above, and those of: Individual #131 (1/24/11 to 1/12/12); and Individual #7 (7/18/11 to 8/2/11). Thus, the MOSES evaluations were reviewed in a timely manner for 14 of the 20 individuals (70%). The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 19 individuals (Individual #55 was not receiving antipsychotic medication and, thus, monitoring with the DISCUS was not required) identified documentation that the DISCUS was current, and had been performed quarterly for the past year for all but the following two individuals (date of most recent DISCUS evaluation): Individual #94 (no DISCUS in record); and Individual #125 (only 1/17/12 DISCUS in record – no prior documentation found). Thus, documentation that the DISCUS had been performed as specified was present for 17 of the 19 individuals (89%) who required this monitoring. The prescribing practitioner had signed all of the completed DISCUS evaluations that were found in the sample records within seven to 10 days of completion (100%). The numbers and specific information for the individuals whose records comprised this sample have been provided to enable the Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for this review.	

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		The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. The Psychiatry Assistant also performed the DISCUS for those individuals who were receiving Reglan, and the Nurse Case Manager performed the MOSES evaluations. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five individuals (21% of those fitting the above criteria) was selected: Individual #312, Individual #181, Individual #260, Individual #191, and Individual #263. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four individuals (80%). The missing documentation was for Individual #312, for whom no documentation of a MOSES evaluation could be found from 2/11/11 until 1/17/12. However, the only individual in this sample for whom the documentation had been signed in a timely manner was Individual #260 (20%). The four individuals for whom there had been a prolonged interval between the completion of the evaluation and the review by the prescribing practitioner were as follows (gap between evaluation and review): ▪ Individual #312 (2/11/11 to 3/31/11); ▪ Individual #181 (1/3/12 to 1/19/12); ▪ Individual #191 (7/10/11 to 8/1/11); and, ▪ Individual #263 (1/15/11 to 2/10/11, 7/1/11 to 7/28/11, and 1/3/11 to 1/19/11). The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated that these evaluations were completed as specified for all five of the individuals (100%). However, the prescribing practitioner had not uniformly reviewed and signed these evaluations in a timely manner for any of the five individuals in the sample (0%). The interval between the date of the evaluation and the prescribing practitioner review for these individuals was: ▪ Individual #312 (7/14/11 to 7/28/11); ▪ Individual #181 (10/20/11 to 11/2/11, and 7/14/11 to 7/28/11); ▪ Individual #260 (7/15/11 to 7/28/11, and 10/21/11 to 11/2/11); ▪ Individual #191 (10/20/11 to 11/2/11, and 7/14/11 to 7/29/11); and ▪ Individual #263 (10/20/11 to 11/2/11, and 7/14/11 to 7/29/11). During the Monitoring Team's previous review, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing practitioner reviewed and signed them was discussed with the Psychiatry Department. At that time, staff	

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		indicated that any abnormal findings on these evaluations were reported immediately to the prescribing practitioner. However, there did not appear to be any documentation of this process. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the prescribing practitioner, it would be useful to devise a mechanism to document this process. The monitoring of individuals prescribed Reglan, but not also receiving a psychotropic agent had improved considerably since the prior reviews. However, there continued to be deficiencies with the prescribing practitioner's timely review of these documents. The finding of noncompliance for this section of the Settlement Agreement related to the deficiencies in the completion of these important side effect monitoring tools, as well as the delays in the timely review by the prescribing practitioner.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 20 individuals (16% of those receiving psychotropic medication) indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 18 individuals (90%). Extensive documentation was missing from the record of Individual #155, which prevented a full assessment of this factor. In addition, while onsite, on 3/22/12, a member of the Monitoring Team attended the ISP for Individual #51. During this meeting, which individual's Attending Psychiatrist attended, the team had an extensive discussion of the diagnosis of dementia, which was neither addressed in the diagnostic formulation nor elsewhere in the psychiatric section of the record. The Monitoring Team's previous review found that 80 percent of the records contained an adequate justification for the psychiatric diagnosis of record. However, at the time of prior reviews, it was noted that documentation of the symptoms that substantiated the psychiatric diagnosis were often found in different sections of the record, and were not present in a coherent manner. The current review found that this documentation could be located in the following three sources in the record: 1) the newly formatted CPAs; 2) the Quarterly Psychiatric Clinic review forms; and 3) the "Psychiatric Consultation – Diagnostic and Treatment Analysis." This section of the Settlement Agreement also addresses the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in LBSSLC documentation as the "target behaviors" of the psychotropic	Noncompliance

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		medication. As noted above with regard to Sections J.8 and J.9 of the Settlement Agreement, a persistent problem with the documentation in the LBSSLC records was the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis. This issue is discussed in more detail with regard to Section J.9. The question of the efficacy of the prescribed psychotropic medication is also referred to in this section. In eight of the 20 records reviewed (40%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. These records were those of the following individuals: Individual #197, Individual #75, Individual #279, Individual #94, Individual #108, Individual #137, Individual #99, and Individual #125. The record of Individual #155 was missing sections of the record that were necessary to make this determination. LBSSLC Psychiatry and Psychology Progress Notes routinely carried forward two years of objective behavioral data. This was extremely valuable and clinically useful historical information. The utility of this information would be greatly enhanced by including a longer longitudinal summary of the contemporaneous behavioral data that would support the subjective rationale for any medication changes that had occurred. The length of longitudinal data that would be required would vary according to the individual, but could extent back for several years. This data would also greatly benefit the determination of efficacy required for the justification of medications as discussed in more detail with regard to Section J.11 above. This database also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be effective from an empirical perspective. The issue of polypharmacy also impeded the assessment of efficacy for some of the individuals, as discussed with regard to Section J.11. As progress is made in reducing the use of polypharmacy, it becomes easier to empirically justify the use of the remaining medications. The final section of this provision relates to the frequency with which the Psychiatrist reviewed individuals receiving psychotropic medication. This review of a sample of the medical records indicated that Quarterly Reviews were performed as specified in this provision for 11 of the 20 individual records reviewed (55%). The individuals whose records that did not contain the necessary information to document Quarterly Reviews were as follows (deficiencies in parentheses): ▪ Individual #155 (missing documentation); ▪ Individual #124 (gap 6/27/11 to 10/13/11 and 10/13/11 to 2/3/12);	

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		▪ Individual #131 (gap 6/21/11 to 10/17/11); ▪ Individual #22 (most recent Quarterly Review dated 10/17/11); ▪ Individual #51 (gap 6/24/11 to 10/17/11 to 2/2/12); ▪ Individual #239 (gap 10/17/11 to 2/2/12); ▪ Individual #94 (none present); ▪ Individual #99 (gap 10/17/11 to 2/1/12 and 6/24/11 to 10/17/11); and ▪ Individual #125 (10/17/11 to 2/2/12). The current 55 percent on-time completion rate was significantly less than the corresponding rate of 90 percent identified in the prior review. The Psychiatry Department might want to determine if this was related to a problem with the routine scheduling of the quarterly evaluations. A member of the Monitoring Team was able to observe the Psychiatric Quarterly review meetings that took place on 3/21/12 and 3/22/12. The individual either attended all or a portion of the meeting depending on what would be clinically appropriate for that person. Those individuals that did not participate in the meeting were observed either before or after the meeting on their residential unit. The duration of the team meetings ranged from 30 to 45 minutes, and there was ample time for team discussion as well interaction with the Individual. The actual content of the meeting is discussed above with regard to Section J.8. Documentation was present to show that the individual had been directly observed in conjunction with the Quarterly Reviews for the entire sample of 20 individuals (100%). The Psychiatry Department had made progress with several of the requirements specified in this section of the Settlement Agreement. Much of this progress was related to the completion of the CPAs, the Quarterly Review documentation, and the "Psychiatric Consultation – Diagnostic and Treatment Analysis" form for those individuals who were receiving psychotropic medication. However, as noted elsewhere in this report, the CPAs still had not been completed for the majority of individuals who were prescribed psychotropic medication. The Facility remained out of compliance with this provision. In addition to issues related to the clinical justification with some diagnoses, problems also continued to be noted with regard to the overlap between the target behaviors for the psychiatric treatment and those included in individuals' PBSPs without adequate justification, questions regarding the efficacy of the medications, and concerns related to adequate data to make long-term decisions. In addition, during this review, problems were noted with regard to the timeliness of quarterly reviews.	

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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.	The review of the Rights/Consents sections of the records for the sample of 20 individuals receiving psychotropic medication indicated that eight individuals (40%) had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for all of the 20 individuals (100%). However, as noted below, there were significant deficiencies related to the consent process that raised concerns about the degree to which these consents were truly "informed." As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit analysis that was contained in the Psychiatry section of the record demonstrated considerable improvement, as compared to the results of prior reviews. The corresponding discussions in the Human Rights section of the record and/or the information utilized to provide consents on behalf of the individual did not yet reflect the additional information that had been added to the other sections of the record. The above-referenced systemic deficits in the risk-versus-benefit discussion made it difficult, if not impossible, for a guardian or the Facility Director to render a truly informed consent regarding the use of psychotropic medication. The Psychiatry Department was aware of these deficits and, as noted above, had made noticeable progress in addressing them. The Facility remained out of compliance with this provision. Future reviews will assess the degree of progress that the Facility has made in integrating the information obtained from the risk-versus-benefit analysis process into the consent process.	Noncompliance
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Based on the Monitoring Team's observation on 3/21/12, the Neurologist, the Director of Psychiatry, the Medical Director, the individuals' Primary Care Provider (PCP), and other members of the professional team, attended the Neurology Clinic. A member of the residence's nursing staff accompanied the individual to the Clinic, and an additional nurse 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 were also available to the Neurologist. A discussion followed the review of each case presentation. These discussions were quite detailed, and involved the Neurologist, Psychiatrist, and the PCP. Also, where	Substantial Compliance

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		appropriate, there was a discussion of the relevant published literature. 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 eight individuals within the sample 20 individuals who required and received neurological consultation within the last year. The review of records indicated that during this time period, the Neurologist reviewed the following individuals: Individual #197, Individual #279, Individual #94, Individual #137, Individual #125, Individual #239, Individual #51, and Individual #124. The Neurology Consultation Note documented the attendance of the Psychiatrist in seven of the eight individual records (88%). Those seven individuals were as follows: Individual #197, Individual #279, Individual #124, Individual #94, Individual #125, Individual #137, and Individual #51. A Consultation Note, dated 3/31/11, for Individual #239 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 describing the substance of the Neurology Consultations 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 observed in the Neurology Clinic during the current and previous onsite reviews. The review of the related documentation confirmed the presence of the Psychiatrist at these meetings in all but one instance in the sample of records reviewed. 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 Psychiatry, Neurology, and Primary Care. 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 individuals served. 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	

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		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. In light of these observations, the Facility remained in substantial compliance with this provision.	

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

1. LBSSLC should ensure that all staff members involved in the use of chemical restraints are trained to describe the antecedents to the events that precipitated the need for the chemical restraint, in addition to the individual's overt behavior. This training should include the proper completion of the section of the forms that inquire about the interventions that were utilized to avoid using chemical restraint. (Section J.3)
2. The Facility should endeavor to have the forms related to each instance of chemical restraint fully completed. (Section J.3)
3. LBSSLC should ensure that the current group of forms that were to be completed to monitor an individual's status after the administration of pre-treatment sedation are completed as specified, and that all of the actual steps that are identified are uniformly carried out. (Section J.4)
4. The initiative to develop and implement Desensitization Plans and/or other strategies to reduce the need for pre-treatment sedation should be accelerated. (Section J.4)
5. The initiative to make it possible for the individuals' treating Psychiatrist to attend their annual ISP meeting should be supported. (Section J.8)
6. The Facility should expand the information that is included in the ISP regarding the individual's psychiatric status. This should include a brief description of the Psychiatrist's contribution to the process where appropriate, as well as integration of the psychiatric treatment plan into the overall ISP. In addition to the psychiatric treatment plan being included in the action plan section, the Facility might want to consider adding a distinct sub-section to the documentation to ensure that the discussion regarding the plan is consistently present. (Section J.8)
7. The Facility should consistently implement the newly developed method to ensure that the differentiation of those behaviors that are related to the psychiatric diagnosis and those that are derived from behavioral factors is clearly described in the Functional Analysis and PBSP. (Section J.9)
8. The Facility's efforts to describe clinical risk-versus-benefit considerations in a number of relevant sections of the individuals' records should be further developed and expanded. (Section J.10)
9. The Facility should fully integrate the progress that has been made with regard to the discussion of the risk-versus-benefit analysis related to the use of psychotropic medication into the material utilized to obtain guardian consent for the use of those medications. (Sections J.10 and J.14)
10. 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 can be clinically justified. (Section J.11)
11. 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. (Sections J.11, and J.13)

12. LBSSLC should develop a mechanism to ensure that the prescribing physician reviews the MOSES and DISCUS side effects monitoring forms in a timely manner. (Section J.12).
13. The Psychiatry Department should investigate the possible reasons for the decline in the timely completion of the Quarterly Psychiatric Reviews. (Section J.13)
14. The Facility should explore methods to provide a fuller description of the deliberations that occur at the HRC meetings with regard to their thorough reviews and discussions of PBSPs and the related use of psychotropic medication. (Section J.10 and J.14)
15. 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)
16. The Facility should evaluate quality, as well as the presence or absence of an item, when performing the internal QA Reviews. (Facility Self-Assessment)
17. The Facility should incorporate the results of their internal QA record reviews into their self-assessment process. (Facility Self-Assessment)

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

1. The Facility should proceed to implement the plan to reassess individuals not receiving psychotropic medication who were last evaluated several years ago with the Reiss Screen. (Section J.7)
2. The Facility should consider utilizing either the commercially available or manual scoring for the large-scale administration of the Reiss Screening instrument to the individuals who have not been evaluated in several years. (Section J.7)

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: o **Review of Following Documents**: o Section K Presentation Book – developed by Jim Forbes, Director of Behavioral Services: o For Section K.4, Positive Behavior Support Plans (PBSPs), and Monthly PBSP Progress Notes, as provided, for: Individual #6, Individual #304, Individual #116, Individual #237, Individual #230, Individual #124, Individual #165, Individual #94, Individual #31, Individual #184, Individual #240, and Individual #57; o For Section K.4, Safety Plan for Crisis Intervention (SPCI), and Safety Plan Progress Note, as provided, for Individual #240 and Individual #124; o For Section K.5, Structural and Functional Assessment Reports (SFARs), as provided, for: Individual #6, Individual #116, Individual #237, Individual #230, Individual #124, Individual #271, Individual #165, Individual #94, Individual #31, Individual #184, Individual #190, Individual #240, Individual #57, and Individual #156; o For Sections K.5 and K.6, Psychological Assessments, including the Inventory for Client and Agency Planning (ICAP) Evaluations, as available for: Individual #57, Individual #6, Individual #184, Individual #35, Individual #306, Individual #116, Individual #237, Individual #94, Individual #31, Individual #190, Individual #104, Individual #124, Individual #14, Individual #97, Individual #165, Individual #271, Individual #139, Individual #230, Individual #3, Individual #240, Individual #115, Individual #192, Individual #78, and, Individual #156; o For Section K.7, Psychological Assessments, as available for: Individual #57 and Individual #31; o For Section K.8, Psychological Assessments, Individual Support Plans, counseling treatment plans, counseling progress notes, as available for: Individual #7 Individual #124, and Individual #240; o For Section K.9, PBSPs, as available for: Individual #6, Individual #116, Individual #237, Individual #156, Individual #57, Individual #165, Individual #271, Individual #230, Individual #124, Individual #94, Individual #31, Individual #190, Individual #240, and Individual #184; o Sub-sample for Section K.9, PBSPs and related consents (on-site review), as available for: Individual #6, Individual #116, Individual #237, Individual #230, Individual #124, Individual #165, Individual #94, Individual #31, Individual #184, and Individual #190; and, o For Section K.10, Monthly PBSP Progress Notes, for the last three months, as provided, for: Individual #6, Individual #304, Individual #116, Individual #237, Individual #230, Individual #124, Individual #165, Individual #94, Individual #31, Individual #184, Individual #240, and Individual #57. o **Interviews and Meetings with the following**: o Jim Forbes, Director of Behavioral Services; and Carolyn Milton, Assistant Director of

	Behavioral Services, on 3/19/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant, Director of Behavioral Services; and Bob Robbins, QA/QI Program Compliance Monitor, on 3/20/12; o Mary Ortiz, Director of Competency Training and Development, on 3/20/12; o Lola Walker, Qualified Developmental Disabilities Professional (QDDP) Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, QDDP Educator; Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 3/20/12; o Psychologists and Psychology Assistants, including Philip Kite, Raul Jamie Trevino, Joanna Molleca, Jody Ramos, Christina Sosa, Krista Leubner, Beckie Crawford, Jose Fragoso, Amber Flores, Melissa Faults, Lamecca Abduljaami, Brandi Jackson, and Nicole Holstein, on 3/20/12; o Tracey Snow Murphy, Director of Residential Services; and Marilyn Foster, Program Compliance Monitor, on 3/21/12; o Rodshadi Moore, Active Treatment Supervisor, Adrian Richardson, Active Treatment Coordinator, Kimmie Scott-McGiruder, Active Treatment Coordinator, and Erika Flores, Active Treatment Coordinator, on 3/20/12; o Rodshadi Moore, Active Treatment Supervisor, on 3/22/12; o Record review, assisted by Jody Ramos, Administrative Assistant, Behavioral Services, on 3/22/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and Texas Tech faculty and students, on 3/22/12; and o Laura Anciso, Director of Vocational and Day Programs; and Rosie Driver, Supportive Employment Coordinator, on 3/22/12. o **Observations Conducted**: o ISP Meeting for Individual #259, on 3/20/12; o Psychiatric Clinic, on 3/21/12; o Staff training (PBSP) for Individual #271 at 514 S. Cedar, on 3/21/12; o Desensitization Committee Meeting, on 3/22/12; o Staff training (PBSP) for Individual #33 at 513 S. Cedar, on 3/21/12; o Behavior Support Committee Peer Review Meeting, on 3/22/12; o Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the day and/or evening hours at the following sites: ▪ Birch (514), on 3/20/12; ▪ Elm (515), on 3/20/12; ▪ Aspen (513), on 3/20/12; ▪ Gym (512), on 3/20/12; ▪ Fir (516), on 3/21/12; ▪ Maple (517), on 3/21/12; ▪ Zinnia (528), on 3/21/12;

	▪ Iris (527), on 3/22/12; and ▪ Tulip (526), on 3/22/12.
	Facility Self-Assessment: 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 the Program Compliance Monitor conducted reviews using the self-assessment tool during the month of January 2012. However, summary data from these reviews was not available for review. According to verbal reports, no additional assessments were conducted in February or March 2012. Verbal reports from the Director of Behavioral Services Department, as well as the PCM indicated that the Facility was considering replacing the current monitoring tool with broader quality indicators. At the time of the current Monitoring visit, it was unclear whether or not this self-assessment tool would continue to be utilized. The Facility had developed a Self-Assessment with regard to Section K of the Settlement Agreement. The 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 Self-Assessment, 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. The Facility appeared to take a thoughtful and useful approach when identifying and examining the many items utilized to assess progress within sections of Self-Assessment. The use of the BCBA certification in addition to adequate professional staff-to-individual ratios appeared straightforward criterions (Sections K.1 and K.13). In addition, monitoring the adequacy of attendance at BSC meetings by both internal and external peer reviewers appeared meaningful, as well as continued tracking of other peer review activities (Section K.3). The Facility might consider tracking a percentage of time external reviewers spend in peer review versus other more consultative activities. Items examining the nature of data collection appeared to target the accessibility of systems as well as their quality (Sections K.4 and K.10). This included the review of permanent products during compliance reviews, as well as additional reviews (e.g., of Monthly PBSPs notes). Self-reports indicated that these reviews evidenced results that were not yet adequate and efforts to improve these systems were underway. Self-review of psychological assessments and SFAs appeared to target the timeliness of these completed assessments, as well as highlighted plans to continue to improve systems to review their quality (Sections K.5, K.6, and K.7). Items utilized to examine the adequacy of psychological services (other than PBSPs) targeted the utilization of SAPs as the format for treatment plans and notes (Section K.8). The Facility also might consider evaluating a sample of theses SAPs using the self-monitoring form that recently was developed. The Facility was using data on the behavioral services grid to examine the timeliness of PBSPs. In addition, the Facility might consider examining and reported estimates of the overall quality of a sample of PBSPs now

	that a new format is being utilized. The Facility did report closely monitoring readability levels. It was self-reported that the Facility would begin to examine the integrity of PBSP implementation, including inter-rater reliability, using a newly developed rubric (Sections K.10 and K.11). Lastly, self-reports indicated that a system to track the adequate completion of competency-based training for direct support professionals and supervisors had not been developed (Section K.12).
	Summary of Monitor's Assessment: Progress was noted in regard to psychologists pursuing BCBA credentialing including the continued completion of necessary coursework and required supervision. Recently, one psychologist had passed the BCBA exam and was promoted to Assistant Director. In addition, internal and supplemental external peer review continued to demonstrate improvement. The collaboration between LBSSLC and Texas Tech University had evidenced positive outcomes, including improved accessibility of data collection systems, in addition to contributing to critical peer review. Similar improvement was noted in the development of more comprehensive Monthly PBSP Progress Notes, including graphic data display. However, inconsistencies between displayed data and PBSPs, as well as concerns with the timeliness and adequacy of review were noted in some cases. In addition, summary and analysis of Inter-observer Agreement (IOA) data continued to be lacking. Although psychological assessments were completed or updated annually, most remained inadequate due to outdated standardized tests of intelligence and adaptive behavior. However, recent re-adjustment of staff responsibilities will likely support improved completion of these standardized assessments. Review of Structural and Functional Assessment Reports (SFAR) noted continued improvement and found those sampled to be adequate. Recently, the development of a self-monitoring tool, as well as a change in format likely will assist psychologists in maintaining the quality of SFARs. Progress was noted in the provision and monitoring of psychological services as initial improvements in counseling treatment plans was noted. In addition, continued improvement in the quality of PBSPs was observed. A qualitative change in the format of PBSPs that was currently underway appeared likely to offer enhanced accessibility as well as utility in the assessment of treatment integrity. Limited progress was noted, however, in developing procedures and methods to ensure that staff received competency-based training.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs	Since the Monitoring Team's last visit, some progress continued to be observed within the Department of Behavioral Services with regard to Psychologists pursuing Board Certified Behavior Analysis (BCBA) credentialing. That is, in September 2011, one Psychologist successfully passed the BCBA exam. This Psychologist recently was promoted to Assistant Director of Behavioral Services. However, one staff member who had previously obtained his BCBA passed away. Subsequently, at the time of the review, only two individuals within the department had their BCBAs. That is, of the current 11	Noncompliance

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	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.	Psychologists (including the Director and Assistant Director), only two (18%) were BCBAs. With the recent change in administrative structure (discussed in further detail with regard to Section K.2 of the Settlement Agreement), there was an expectation that the Director and Assistant Director would not carry a caseload. However, as the transition related to this administrative change unfolded, the Assistant Director was expected to continue to carry a small caseload for the next few months. Consequently, the Assistant Director was the only one (9%) of 11 Psychologists with a BCBA currently writing PBSPs. According to documentation provided in the Section K action plan, at the time of the current onsite visit, three (33%) of the nine Psychologists had completed the required coursework and all their necessary supervision. All three of these Psychologists planned to take the exam in May. Two of these Psychologists did take the exam in January 2012, but did not pass. Currently, the only Psychologists not taking classes and/or receiving supervision were the two newest Psychologists within the department, who were recently hired. Verbal reports indicated that these individuals planned to enroll in classes this summer. Overall, documentation provided (i.e., examples of supervision sheets) indicated that staff completing coursework also were receiving supervision. Verbal reports from these staff indicated that supervision was not consistent at times. The Facility is encouraged to ensure that all eligible staff receive supervision consistent with the required Behavior Analyst Certification Board (BACB) supervision requirements. Consistent with previous observations, verbal reports from behavioral services staff continued to reflect a desire for advanced educational competencies, including the BCBA certification, for psychology assistants. Evidence provided indicated that the Facility was exploring the potential of offering similar coursework options to current Psychological Assistants similar to that of current Psychologists. As previously noted, this opportunity for additional Facility employees to pursue certification would likely promote the recruitment and retention of competent professionals already within Behavioral Services. The Facility was rated as being in noncompliance with this provision item 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	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	Substantial Compliance

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	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.	been employed in his current position for over ten 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 current review, it was observed that a change in administrative structure recently had taken place. This change included the addition of an Assistant Director of Behavioral Services position. This change appeared to have been positively received by Psychologists and Assistant Psychologists, especially recently hired Psychologists. More specifically, the Assistant Director has been available to provide additional administrative oversight and clinical support to all behavioral services staff, and also was significantly involved in the training of recently hired Psychologists. Recent verbal reports from Behavioral Services staff reflected a high degree of support and confidence in the Director and Assistant Director of Behavioral Services in maintaining a consistent level of psychological care throughout the Facility. The Facility was rated as being in substantial compliance with this provision item based on the current positive reports of Behavioral Services staff members, as well as the continued improvement in the provision of psychological services observed since the last visit.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	As similar to previous reports, progress continued to be evident in the current peer-based systems implemented to review psychological services. As noted in previous reports, LBSSLC had an internal peer review system that occurred through the Behavior Support Peer Review Committee (BSC) Meetings. Professionals from a diversity of disciplines and departments were expected to attend these meetings, including Psychologists, Psychology Assistants, medical representatives (RN or MD), a Psychiatrist, a QDDP, a Speech Language Pathologist, a human rights officer (HRO), quality assurance staff, and BCBAs. As noted in the Monitoring Team's previous report, although this committee met regularly, review of BSC meeting minutes (from 3/31/11 to 8/19/11) revealed that many of the more inexperienced Psychologists attended less than 50% of the BSC meetings. In response to this concern, the Facility now required all Psychologists to attend BSC at least monthly. Review of BSC meeting minutes completed since the previous onsite visit revealed that committee meetings were held at least once during 17 (77%) of the 22 weeks between 10/14/11 through 3/9/12. In total, during these 17 weeks, 19 meetings were held. Overall, these meetings were well attended by the Director and/or Assistant Director of Behavioral Services, who were each in attendance approximately 63% of the meetings. However, at least one was in attendance at 100% of the meetings. In general, it appeared	Noncompliance

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		that one or more Psychologists, one or more Psychological Assistants, a QA/QI Department staff, and one or more speech language professionals were in attendance in approximately 94%, 84%, 74%, and 74% of BSC meetings, respectively. The Human Rights Officer was in attendance at 42% of the meetings. Attendance by medical staff, including psychiatry or nursing, was not evident in any of the documentation provided. It appeared that the Facility was responsive to the previous observation that some Psychologists, especially those with limited experience, appeared not to regularly attend BSC meetings. Based on current meeting minutes, it appeared that two or more psychologists attended 68% of the meetings with the majority of Psychologists attending at least one BSC meeting per month during December, January, February, and March 2012. Indeed, it appeared that the total number of Psychologists attending meetings increased over time. This was an improvement since the last Monitoring visit. During the previous review, it was noted that, in addition to the internal peer review completed through BSC, the external review process appeared much more robust. At that time, the frequency of external review as well as the diversity of peer reviewers had increased. Consultants from Texas Tech University primarily provided external review. They provided onsite and offsite consultation, peer review, and in-depth case review. 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 students studying Special Education and Applied Behavior Analysis. In addition, at that time, external peer review was also supplemented through the participation of Psychologists, including BCBAs, from other State Facilities. Currently, documentation provided indicated that the involvement of the consultants from Texas Tech had continued with estimates reflecting approximately over 100 hours of on-site and off-site involvement per month. This involvement included critical case review at BSC meetings as well as other work, including the development of communication strategies, training on conducting preference assessments, the development and monitoring of PBSPs and data collection systems, and staff training. Indeed, ongoing documentation (i.e., "Log of External Reviews/Behavior Analytic Support by Texas Tech University") demonstrated a substantial amount of efforts directed at individual case review as well as other behavior analytic supports. In addition, other professionals, including Psychologists from other State Facilities also continued to support ongoing external review through participation in BSC. That is, BCBAs and other Psychologists from Austin SSLC attended BSC via phone conference. Overall, based on documentation provided, it appeared that external peer reviewers, from either Texas Tech or Austin SSLC, participated in eight (42%) of the BSC meetings since the last Monitoring review.	

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		It should be noted that in addition to the BSC meetings, other meetings were held for Behavioral Services staff. Indeed, Behavioral Services Meetings were held to promote and support the work of Behavioral Services staff. According to documentation provided, since the Monitoring Team's last visit, seven Behavioral Services Meetings were held. Similar to previous descriptions in the Monitoring Team's past reports, the Monitoring Team's direct observation of the BSC continued to reflect diverse attendance and committee members' active participation, presentation of assessments and plans by their authors, and data-based review and decision-making. Overall, critical peer review continued to be observed in a supportive atmosphere of learning and collegiality. However, as subsequently presented with regard to Section K.9, the annual review of PBSPs and SPCIs had been inadequate. More specifically, review of the most current Behavioral Services tracking grid, dated 3/7/12, indicated that recorded BSC approval and/or expiration date had exceed 12 months for 16 (11%) individuals with PBSPs. In addition, review of the Behavioral Services tracking grid for Safety Plans for Crisis Intervention, dated 2/13/12, revealed that the recorded BSC approval expiration date as well as the HRC expiration date had exceeded 12 months for one (20%) of the five individuals with a SPCI (i.e., Individual #4). Since the last review, attention had been directed toward training psychology staff in how to more closely monitor their caseloads, and, when necessary, make referrals to BSC for case consultation and peer review. This training was conducted with both QDDPs and Psychologists in January 2012. Since this training, documentation indicated that referred case consultations were held during BSC for at least two individuals. In February 2012 (for Individual #315), and March 2012 (for Individual #183), the BSC's discussions addressed concerns regarding current case status, and were not held primarily to address annual approval. In addition, closer monitoring of challenging behavior and related supports had been initiated at the Incident Management Review Team (IMRT) Meetings, where reported incidents as well as current PBSPs were reviewed to ensure that appropriate supports were in place. Documentation provided included multiple examples of where teams were asked to examine incidents and determine if PBSPs needed to be revised to address current issues (e.g., adding new target behaviors). The current internal system as well as the supplemental external peer review appeared to facilitate more frequent and improved opportunities for case consultation, critical peer review, and the provision of other important clinical supports and services. These additional services were particularly evident in the efforts at enhancing and improving the revised behavioral data collection system that has been implemented Facility-wide.	

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		The increasing trend in more Psychologists regularly attending at least one monthly BSC meeting also was noted in December through March 2012, as well as the ongoing involvement of external peer reviewers in 42% of BSC meetings. Indeed, improvements in both internal and external review were noted. However, one final area remaining for improvement was ensuring timely annual review of PBSPs and SPCIs. As timely review improves and, if the current level of progress observed in internal and external peer review is sustained, the Facility will likely achieve compliance with this component of the Settlement Agreement. Lastly, it appeared that the current policies related to peer review should be revised to be consistent with current practice.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Progress had continued in the area of standardized data collection and data review. Since the Monitoring Team's previous visit, significant efforts had been made to enhance and promote the effective use of a Facility-wide standardized data system. As previously described in the Monitoring Team's earlier reports, this system involved direct support professionals carrying index cards, and, when appropriate, immediately recording data on the target and replacement behaviors of each individual with a PBSP, as well as other relevant data. Recent efforts aimed at increasing the integrity of this data system had occurred through the collaboration with Texas Tech graduate students and faculty members. This involved substantial efforts, including assessment, training, monitoring of compliance, dissemination of progress information, and enhancement of responsibilities of and performance feedback to key staff (i.e., Home Team Leaders, and Assistant Home Team Leaders). According to data collected as well as verbal report from Texas Tech representatives and Behavioral Services staff, the recent efforts had improved the accessibility and use of the index cards. Direct observations by one of the members of the Monitoring Team during informal site visits also reflected improvement in the accessibility of the index cards. That is, 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, the Monitoring Team member asked residential staff if they were available. At the Monitoring Team's previous visit, it was estimated that the data cards were immediately available for use (i.e., carried by the staff) in approximately 75% of the residential programs visited. A similar estimate was made at the time of the Monitoring Team's current visit. That is, it was estimated that the data cards were immediately available for use (i.e., carried by the staff) in approximately 75% of the residential programs visited. More specifically, out of the eight residential programs visited, staff in two of the programs did not have index cards readily available. Recent verbal reports from direct support professionals were similar to those noted at the previous visit. They continued to reflect a positive view of this system (i.e.,	Noncompliance

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		accessible, feasible, and effective). Documentation provided during the Monitoring Team's previous visits evidenced the initiation of system-wide collection of inter-observer agreement (IOA) data. Since the Monitoring Team's last visit, documentation evidenced the continued collection of IOA data. However, documentation provided did not include a summary of data collected indicating systematic monitoring and evaluation (further information is provided on this with regard to Section K.10 of the Settlement Agreement). To examine the nature of data collection, including standard procedures and methods typically utilized to summarize, monitor and review progress, a sample of 12 individuals who had an ISP meeting within the last six months and also had PBSPs were selected and reviewed. A list of these individuals is included above in the documents reviewed section. This review included the examination of current Positive Behavior Support Plan, Monthly PBSP Progress Notes (last three months), Safety Plan for Crisis Intervention, and Safety Plan Progress Notes (last three months), as available. In general, since the Monitoring Team's earlier visits, these notes continued to show improvement, because data appeared more effectively displayed. Although improved, some concerns regarding the use of appropriate graphing conventions continued to be observed (more specific information regarding noted improvement in graphing conventions is discussed with regard to Section K10). Review of documentation indicated that all of the 12 (100%) individuals had Monthly PBSP Progress Notes completed across a number of consecutive months (a few individuals were missing a note from one of the months sampled). In 10 of the 12 graphs (83%), data for both target and replacement behaviors were displayed. Replacement behavior(s), however, were not included in the graphs for Individual #57 and Individual #31. The PBSP for Individual #31 was a relatively new plan and a replacement behavior had yet to be identified through completion of a functional behavioral assessment. Although, at a minimum, at least one or more target and replacement behaviors appeared to be displayed in most monthly notes (i.e., except for those identified above), there were some concerns noted about the adequacy of the data display. That is, inconsistencies between the operational definitions found in the PBSPs and the data displayed within the corresponding monthly notes were found for five (42%) of the individuals sampled. For example, additional data was displayed that was not identified or defined in the PBSP, or target behaviors and/or replacement behaviors that were defined in the PBSP were not graphed (e.g., "making choices" for Individual #304; "calmness," "SIB," and "stealing" for Individual #116; "communication," "fire starting," and "malingering" for Individual #237; "functional communication," "verbal aggression," "hallucinations," and "UAD [Unauthorized Departures]" for Individual #124; "aggression"	

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		for Individual #184). In addition, some target behaviors that were individually defined in the PBSP were then combined when graphed (e.g., Suicidal and homicidal threats for Individual #124). As presented, monthly PBSP notes were available for all of the individuals sampled. However, concerns were noted with regard to the adequacy and/or timeliness of the review for five (42%) of the sampled notes. For example, comments within the monthly notes contained: 1) reports of missing data (e.g., "no documentation on his participation in activities" for Individual #304 that appeared to last for eight or more consecutive weeks); 2) content that appeared to be simply cut-and-pasted from previous weeks (e.g., January and February note for Individual #116); 3) descriptions that did not appear to be helpful or related to the target behaviors (e.g., "cold week" and "she enjoyed seeing the little bit of snow we got" for Individual #184); and 4) weekly progress was either missing (e.g., missing three weeks of progress notes in February for Individual #94) or appeared not to be completed in a timely manner (e.g., December note completed on 2/15/12 for Individual #230, and December progress note was completed on 3/14/12 for Individual #184). Currently, documentation evidenced the Facility's responsiveness to previously identified concerns regarding the accurate display of data. That is, previous observations noted limitations with data display when it could not be determined if a zero level of responding that was displayed in graphs was accurate or reflected the unintentional display of the absence of data. The Facility responded to these concerns by training behavioral services staff to leave blanks in cells when no data is available and to closely monitor and highlight in Monthly Notes, when appropriate, the number of days within the reporting period where data was missing. In addition, the Facility reported that a process recently had been implemented to review and provide closer oversight of completed Monthly Progress Notes on an ongoing basis. All of these new procedures are likely to enhance data monitoring and review. To determine the nature of data collection related to the implementation of Safety Plans for Crisis Intervention, two individuals with SPCIs were sampled and the last three months of Safety Plan Progress Notes were requested. Unfortunately, only documentation for Individual #240 was provided for review (i.e., documentation was not available for Individual #124). Monthly notes for December, January, and February for Individual #240 displayed the frequency of restraint, total and average duration (in minutes) of restraint, chemical restraint, and injuries related to restraint in table and graphic format. In addition, these monthly summaries all appeared to be completed in a timely manner. Documentation as well as verbal reports from the Director of Behavioral Services indicated that the use of the Safety Plan progress notes will be discontinued in April 2012 and data related to restraint (as described) will be integrated within the	

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		Monthly PBSP Notes. Although the Monitoring Team's previous reports have examined the nature of data display in PBSPs, the current review did not examine these documents. This was based on verbal reports as well as documentation that revealed that the format of the PBSP had qualitatively changed and would not continue to include data display using tables or graphs. Currently, identifying whether or not assessments or interventions had been modified due to lack of progress or to a change in functioning was difficult. That is, programmatic changes in PBSPs or SFARs due to lack of progress or behavioral deterioration was not overly conspicuous. For example, the sample of SFARs that were currently reviewed (i.e., as described with regard to Section K.5) did not include an obvious rationale for their completion or revision. In addition, rationales on sampled PBSPs (i.e., as described with regard to Section K.9) typically indicated the revision was in response to the ISP, to a revised SFAR, or to changes in psychotropic medication. None of the PBSPs included a rationale reflecting revision due to limited progress or deteriorating functioning. It appears that the majority of revisions or updates (of assessment and interventions) typically occurred concurrent with the ISP cycle or adhered to the initial completion, implementation, and/or consent date. Indeed, it is likely that most were based on a schedule to minimize lapses in required consents. However, newly developed procedures implemented to assist psychologists in determining if a revision of the SFBA was necessary might facilitate more responsive modifications (more specific information is included with regard to Section K.5). Also, weekly progress reviews in Monthly PBSP Progress Notes appeared to be an appropriate method for highlighting the need for revisions in assessment or behavioral programming based on current functioning. Current examination of Monthly PBSP Progress Notes indicated that weekly reviews often mentioned changes in medication (e.g., Individual #94), influences of environmental variables (e.g., Individual #165, February 2012), and/or implementation of strategies outlined PBSPs (e.g., Individual #31). And, in some cases, a few Monthly Notes included references to programmatic changes (e.g., Individual #156, February 2012; Individual #190, January 2012). Although in one of these cases (i.e., Individual #156), it was not clear that described changes were based on analysis of collected data. To more overtly demonstrate that assessments and/or interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed, the Facility should consider ensuring that, when these changes do occur, corresponding changes are reflected in the rationales of SFARs and PBSPs as well as highlighted in Monthly PBSP Notes. Overall, the standard methodology for data collection, monitoring and review continued	

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		to reflect improvement. This was especially true regarding efforts to improve the integrity of the data collection system. However, it was still not consistently evident while examining Monthly PBSP Notes that the system promoted an active and accurate process in making data-based treatment decisions.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	Since the Monitoring Team's last visit, some progress was noted in development and implementation of psychological assessments. As reported in the Monitoring Team's previous reports, each individual residing at the Facility was required to have a current psychological assessment that was completed or updated at least annually. This requirement involved the inclusion and review of data from the most recent 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 determine whether or not psychological assessments were based on current, accurate and complete clinical and behavioral data, a sample of 24 individuals, who each had an ISP meeting within the last six months, was selected and their most recent psychological assessments were reviewed. These individuals are listed above in the documents reviewed section. This sample represented approximately 11% of the total number of individuals (N=220) expected to have a psychological assessment. It should be noted that the review of the selected sample was somewhat challenging due to the fact that requested documentation often was missing or incomplete (e.g., missing pages of the psychological assessment for Individual #35 and Individual #271, and no ICAP provided for Individual #94 and Individual #3). Of the 24 individuals sampled, 23 (96%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. The exception was the psychological assessment completed and provided for Individual #165 (on 11/19/10). It should be noted that the Behavioral Services grid, dated 3/20/12, indicated that the psychological assessment for Individual #165 was revised more recently (i.e., on 11/10/11) than the assessment currently provided for review. Sampled documentation also indicated that 23 (96%) of those sampled had an ICAP completed within the last three years. The exception was Individual #237, whose ICAP was completed on 1/7/09 (i.e., as listed on the psychological assessment). However, a more recent ICAP (dated 1/2/12) was found within the documentation provided. It was unclear why the ICAP was not completed concurrently with the psychological assessment that was updated on 11/16/11 (i.e., it was completed approximately six weeks after the completion of the psychological assessment). A similar situation also was found for Individual #184 where a more recent ICAP was completed (on 11/14/11) but not	Noncompliance

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		included in the current psychological assessment (on 10/26/11). Additional concerns regarding the inconsistency of scores reported in the psychological assessment and those found on the actual ICAP summary data sheets were found for Individual #31 and Individual #78. Of those sampled, 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. The exception was the psychological assessment completed for Individual #3. It stated that an intellectual assessment could not be completed due to the individual's physical and cognitive disabilities. Of those including results of intellectual testing, only three (13%) assessments had been completed within the last five years. In addition, 14 (58%) of the sampled psychological assessments contained results of previously completed standardized measures of adaptive behavior, utilizing either the Vineland Adaptive Behavior Scale or the AAMD Adaptive Behavior Scales. Of these, two (14%) were completed within the last five years. The remaining psychological assessments included the use of the ICAP as the only measure of adaptive behavior. In general, the psychological assessments appeared to contain information targeting consistent content areas across reports. That is, most assessments provided information on an individual's history, mood/affect, cognitive and adaptive functioning, review of behavioral functioning, as well as medical, physical, and/or psychiatric status, including diagnoses. The inclusion of behavioral data, however, continued to be inconsistent across reports with behavioral data displayed in some (e.g., Individual #190 and Individual #115), but not others. As observed during the Monitoring Team's previous reviews, in addition to the areas of assessments discussed above, 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. Overall, review of the tracking grid of completion dates of psychological assessments, updated 3/16/12, revealed that, with the exception of two individuals, approximately 99% of the assessments had been completed or updated within the last year. The two exceptions included the assessments for Individual #252 and Individual #34 that, as of 3/16/12, were not yet completed. In addition, the completion date provided on the grid for the psychological assessment of Individual #165 (i.e., 11/10/11) might have been an updated revision that was not provided with requested documentation (i.e., the psychological assessment provided, dated 11/19/10, might have been the previous	

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		assessment). Overall, review of the most recent Behavioral Services tracking grid of individuals with SFARs revealed that since the Monitoring Team's last review, 29 were completed. Based on documentation, a total of 136 SFARs had been completed. However, four individuals with PBSPs currently did not have SFARs (i.e., Individual #22, Individual #57, Individual #92, and Individual #20). In addition, based on available documentation, it appeared that approximately 15 (11%) were outdated (i.e., recorded completion date exceeded 12 months of current date). This was an improvement compared with the previously reported estimate (i.e., 15% at the Monitoring Team's previous visit). As described in the Monitoring Team's previous reports, individuals who received behavioral and/or psychopharmacological interventions were required, in addition to psychological assessments, to have a Structural and Functional Assessment Report. To examine the nature of current SFARs, 14 individuals with ISP meetings completed within the last six months and with PBSPs were selected. These individuals are listed above in the documents reviewed section. This sample of individuals reflected 10% of the total number of individuals with PBSPs (N=140), including nine (31%) of the 29 SFARs that had been updated since the Monitoring Team's last review. Unfortunately, review of documentation provided revealed that SFARs were only available for 12 of the 14 individuals sampled. More specifically, SFARs for Individual#116 and Individual #57 were not provided as requested. Of the remaining 12 SFARs, 10 (83%) were completed and/or updated within the past 12 months. That is, SFARs for Individual #10 and Individual #156 included report dates (i.e., 11/2/10 and 12/17/10, respectively) that were in excess of 12 months of the current date. The current review of SFARs evidenced continued improvement in quality. This finding is consistent with evidence noted in the Monitoring Team's previous reports that revealed ongoing progress. SFARs remained comprehensive and, in most cases, adhered to the established format. This format contained content sections including: 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. In addition, all of the SFARs in the sample highlighted assessment findings related to setting events, antecedents, consequences, and potential underlying function(s) of target behaviors. Overall, the quality of the sampled SFARs appeared adequate. That is, the SFARs appeared to include necessary indirect and direct methods of assessment; identification of potential setting events/establishing operations, antecedents, and consequences; identification of underlying function(s) as well as target and replacement behaviors; as well as	

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		description of preferences and likely reinforcers. Areas where the plans appeared improved included the inclusion of a "derivation" section in some, but not all, assessments (i.e., a derivation section was found in SFARs for Individual #124, Individual #271, Individual #31, and Individual #190). Consideration should be given to including an additional "rationale" section that would provide the reasons why the assessments was completed or revised in order to highlight those where target behaviors had not improved or had substantially changed. In addition, although replacement behaviors often were proposed in SFARs, they were seldom operationally defined. This might be an extra step that might be useful (at this assessment stage of the process) as staff members interviewed could assist with the development of a more comprehensive and accurate definition. The current review also evidenced a significant change in format of the SFAR. More specifically, the SFAR recently had been "… reorganized and streamlined to increase utility and decrease completion time." This improvement was apparent in the review of the two SFARs that were sampled (i.e., Individual #31 and Individual #271). The new format was viewed as a significant improvement in organization and appeared to likely enhance the documents ease of use while not sacrificing necessary content. Indeed, the process of finding critical information seemed much more efficient. This new format would benefit from similar additions (i.e., rationale section, operational definition of replacement behavior) as suggested above. The Monitoring Team looks forward to reviewing more SFARs completed in the format during the next visit. The improved quality of the assessments might be due to the use of the revised Structural and Functional Assessment Self-Monitoring Checklist. This rubric (revised in March 2012) was designed for use as both a self-monitoring tool to assist authors in developing adequate and complete SFARs, as well as a checklist for peer reviewers during BSC. Overall, it appeared that this checklist had promoted a high level of quality and should continue to utilized when developing and reviewing SFARs. A second rubric also was developed to assist Psychologists in determining whether or not a SFAR should be updated. If it was determined, for example, that the PBSP target behaviors were biologically derived behavioral symptoms (e.g., of an underlying mental illness) or the individual was hospitalized for an extended period of time, then the SFAR would not need to be updated. However, if other evidence was found, for example, that suggested that not all antecedents related to a target behavior were identified, additional functions were found not to have been addressed, new target behaviors were of concern, or lack of progress overall, than an SFAR would be required to be completed. The Monitoring Team believes that this rubric is a step in the right direction by prompting Psychologists to consider the various factors that might necessitate a re-evaluation and completion of a SFAR and ultimately to make informed, data-based decisions. However,	

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		this rubric should not only be completed prior to the annual ISP. That is, timely modification should occur if no evidence of progress or substantial changes in functioning are noted. In both cases, data-based decision-making should be integral in the resulting programmatic changes. Overall, as presented above, improvement was noted in the timely completion of psychological assessments. However, of those sampled, only 13% had standardized tests of intelligence completed within the last five years, and only 14% had standardized measures of adaptive behavior completed within the last five years. Although improvement was noted with regard to the SFARs, according to the Behavioral Services grid, four individuals with PBSPs still do not have SFARs, and it appeared that approximately 11% were outdated. Lastly, the Facility was in the process of qualitatively changing the format of the SFARs. Given the above findings, the Facility remained out of compliance with this provision.	
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.	Since the Monitoring Team's last visit, minimal progress in ensuring that each individual had a current, accurate, and complete psychological assessment had been noted. However, efforts were noted in re-establishing a system that will likely make substantial progress in this area over the next six months. The Monitoring Team's previous report noted limited progress in the completion of current, accurate, and complete psychological assessments. This was as a result of changes in caseload responsibilities of the identified psychometrician due to previous staffing vacancies. Currently, however, documentation and reports indicated that caseload responsibilities recently had been re-adjusted to allow two Psychologists to spend approximately 50% of their time completing standardized tests of intelligence and adaptive behavior. Positive outcomes associated with this recent change, including the completion of more current intelligence tests and adaptive measures when updating annual psychological assessments, will likely be more conspicuous at the Monitoring Team's next visit. Nonetheless, to determine whether or not psychological assessments were based on current, accurate, and complete clinical and behavioral data, a sample of 24 individuals, who each had an ISP meeting within the last six months, was selected and their most recent psychological assessments were reviewed. As presented earlier with regard to Section K.5 of the Settlement Agreement, of those individuals sampled, 23 (96%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. The exception was the psychological assessment completed on 11/19/10 for Individual #165. Documentation also indicated that 23 (96%) of those had an ICAP completed within the last three years. The exception was Individual #237, whose ICAP was completed on 1/7/09 (i.e., as listed on the	Noncompliance

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		psychological assessment). However, a more recent ICAP, dated 1/2/12, was found within documentation provided. It was unclear why the ICAP was not completed concurrently with the psychological assessment that was updated on 11/16/11 (i.e., it was completed approximately six weeks after the completion of the psychological assessment). Of those sampled, 23 (96%) contained results of previously completed standardized tests of intelligence. The exception was the psychological assessment completed for Individual #3, which stated that intellectual assessment could not be completed due to the individual's disabilities. Of those reporting results of intellectual testing, only three (13%) have been completed within the last five years. In addition, 14 (58%) of the sampled psychological assessments contained results of previously completed standardized tests of adaptive behavior (not including the ICAP). Of these, two (14%) were completed within the last five years. Although minimal progress was noted in completing more current intellectual and adaptive behavior assessments, the revised caseload structure of the two selected Psychologists within Behavioral Services, effective 12/19/11, offered promise that Monitoring Team would find a greater completion rate during the next visit. To assist with this process a grid was developed to track the completion of new psychological testing, including standardized intelligence testing, adaptive behavior scales, and other assessments. According to this grid, since the caseload re-structuring, it appeared that new standardized intellectual testing and adaptive behavior scales had been completed for four individuals. Overall, it appeared that new testing had been conducted with 11 individuals within the last 12 months. The Facility remained out of compliance with this provision.	
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, 23 (96%) had a psychological assessment that was updated within the last 12 months. Sampled documentation also indicated that 23 (96%) of those sampled had an ICAP 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. As previously reported, LBSSLC policy required that a psychological assessment be completed one month from the date of an individual's admittance. According to documentation provided, since the Monitoring Team's last visit two individuals (Individual #31 and Individual #57) were admitted to the Facility. Of these, it appeared the one of the two psychological assessments (50%) were completed within 30 days of admission. That is, the psychological assessment for Individual #57 appeared to be completed and approved, dated 11/18/11, within 30 days of admission. Individual #31 had a "psychological admission summary" that included results of previous testing as well as other meaningful psychological information completed concurrent with his	Noncompliance

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		admission. Although the date of report corresponded with the individual's admission date, the author's signature and related date was more than one month later. An additional report, labeled "psychological assessment," with the same date, contained more recent data that appeared to be collected following his admission to the Facility. For example, this second report included recent ICAP assessment data that was collected within one month of admission. However, the data included in this report appeared inconsistent with data on the actual ICAP testing forms. That is, the reported and actual maladaptive behavior index scores, as well as the overall service score were different across documents. In the end, these reports appeared to be completed more than one month after the individual's admission. It is unclear why the "date of report" did not reflect the actual date that the report was completed. As previously presented with regard to Section K.2 of the Settlement Agreement, since the Monitoring Team's last visit, a new administrative and clinical oversight structure was put in place. At the current time, it appeared that this system was helpful in providing closer monitoring of the timely completion of psychological assessments through more regular and intensive oversight and support. Documentation revealed that almost all individuals had a psychological assessment dated within the last 12 months. Although the timely review of these assessments continued to be noted, the Facility will need to significantly increase the number of more recent standardized intelligence tests as well as adaptive behavior scales to comply with this provision.	
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 progress was noted in the provision and monitoring of psychological services other than PBSPs. Documentation and verbal reports indicated that Behavioral Services staff had assumed more responsibility for developing treatment plans, as well as monitoring and graphing progress of performance on counseling targets based on data provided by therapists. Currently, it appeared that three off-campus community counselors and one onsite Psychologist were providing weekly counseling to 12 individuals. To examine the nature of these psychological services, three of these twelve individuals were selected and their treatment plans, ISPs, psychological assessments, and other available documentation were reviewed. These individuals are identified above in the documents reviewed section. This sample represented 25% of those individuals currently receiving counseling services. Of these three individuals, all (100%) had counseling treatment plans. However, it was difficult to determine when these plans were written, revised, and/or implemented for two (i.e., Individual #7 and Individual #240). Additional review revealed that recommendations for (or discussion of) counseling services were included in the psychological assessments for all three of the individuals (100%). Although counseling supports were identified in the assessment for Individual #7, the last page of the assessment was not provided and, consequently, it was unknown if specific	Noncompliance

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		recommendations were made regarding counseling supports. It was also noted that specific recommendations for counseling (i.e., as reflected in listed objectives in action plans) were found in only two (67%) of the ISPs reviewed. Overall, variation in the quality of the counseling treatment plans continued to be evident. This finding was consistent with the Monitoring Team's previous reviews. Currently, plans for Individual #7 and Individual #240 appeared to include adequate operational definitions; sufficient description of evidenced-based practice; strategies related to supporting generalization; process related to documentation, monitoring, and review of progress; and action criteria for lack of progress. In addition, there was evidence that counseling session notes had begun to be completed for one (i.e., Individual #240) of the three individuals, and recorded and tracked using skill acquisition program (SAP) data sheets for two of these individuals (i.e., Individual #240 and individual #7). These two plans were developed using the new Counseling Skill Acquisition Program format that Facility Psychologists now completed. The third counseling treatment plan (for Individual #124) appeared to be developed using the previous format, and was conspicuously less comprehensive and detailed that the other two plans reviewed. For example, the plan included inadequate operational definitions and treatment goals, and did not provide specification on data collection, review or monitoring, or an action criterion on when to revise the program based on lack of attendance or progress. Indeed, the one monthly report provided did not include any quantitative data on targeted treatment objectives to allow assessment of ongoing progress. It appeared the efforts to develop a standardized format for counseling treatment plans improved the quality of those plans. In the past, Psychologists from Behavioral Services collaborated with external counselors, who were responsible for developing treatment plans. Now, Facility Psychologists were primarily responsible for the development of these plans with input from external counselors. As a result, the revised counseling treatment plans resembled skill acquisition programs. In addition to the new format, Psychologists facilitated the collection of session notes, and were responsible for ongoing monitoring of progress using data tracking sheets (i.e., SAP data sheets). Trainings were conducted with the QDDPs (on 1/20/12) and Psychologists (on 1/27/12) to promote the use of the new system and ensure that external counselors were integrated as much as they were willing within the ISP process. Although progress appeared to be evident in the quality of counseling treatment plans written by Facility Psychologists, minor concerns were observed. For example, two treatment objectives were identified on the Counseling Skill Acquisition Programs for Individual #7 and Individual #240, but four responses were being tracked on the counseling progress notes. This inconsistency might make monitoring and assessment of progress more challenging. In addition, both objectives stated that the individual would	

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		"independently" perform the identified response with "verbal cue" from therapist. This appeared a bit confusing, because the individual would not have performed the response independently if a verbal cue (as defined on the data sheet) were provided. It might be that when using the term "verbal cue," the author of the plan was referring to the discriminative stimulus. To reduce potential confusion, the objective could state, for example: "following the therapist's question (e.g., "can you name one success this week?"), the individual will independently identify at least one success per session for 10 consecutive sessions." Indeed, review of the counseling progress note for Individual #7 reflected inaccurate data collection, because multiple prompt levels were often scored within a single step. In addition, approximately 50% of the sessions had not been completed as scheduled for Individual #7. Overall, it appeared that data collection systems, although not completed accurately, were in place for two (67%) of the individuals sampled (i.e., ongoing data collection related to performance on counseling objectives was not evident for Individual #124). 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. That is, methodology and strategies should be evidenced-based. Consequently, behavioral services staff must 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 baseline and 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 supports appeared counter-therapeutic. For example, recent direct observations and related staff report regarding the use of a sensory diet appeared inconsistent with the PBSP for Individual #33. The previous recommendation of the Monitoring Team remains applicable. That is, the Facility is encouraged to collect data, and determine if these services and supports are effective for individuals for whom they were prescribed. One new area in which evidenced-based methods were evident was in the initial utilization of the Assessment of Basic Language and Learning Skills – Revised (ABLLS) for three individuals (i.e., Individual #60, Individual #116, and Individual #161). This assessment is likely to assist IDTs to identify pre-requisite skills that could be targeted for acquisition in an attempt to support an individual toward a specific objective or goal. In order for the Facility to meet the requirements of the Settlement Agreement for this provision, consistency in quality of counseling treatment plans as well as evidence of consistent and adequate data collection, monitoring and review of these services needs	

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		to be evident. In addition, for other psychological treatments, the Facility should collect data, and determine if these services and supports are effective for individuals for whom they were prescribed.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Progress continued to be noted in developing quality PBSPs. It an attempt to examine the quality of PBSPs, a sample was selected of 14 individuals with PBSPs, and ISPs within the last six months. These individuals are listed above in the documents reviewed section. These 14 PBSPs represented 10% of the total number of PBSPs. In addition, 11 of these individuals had PBSPs updated since the Monitoring Team's last visit. This represented approximately 24% of all the plans implemented since the last visit. Of those selected, the most current PBSP for one individual (i.e., Individual #271) was not provided. Of the available plans, 13 (93%) had been updated within the last 12 months. That is, the PBSP for Individual #184, dated 1/4/11, did not appear to have been updated within the last 12 months. In general, PBSPs appeared quite comprehensive and adhered to a standard format. That is, in most plans, the following content areas were addressed: 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) rights restrictions, including risks and benefits; 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, there were still areas within sampled PBSPs that continued to appear somewhat inconsistent and inadequate and, consequently, did not appear to meet the requirements of the Settlement Agreement. These included: 1) history of prior interventions, outcomes, and rationale for related changes; 2) operational definition of replacement behaviors, especially within staff instructions; 3) complete behavioral objectives that facilitated efficient and accurate progress determination, especially for identified replacement behaviors; 4) data display, including baseline data, especially for replacement behavior(s); 5) conspicuous integration of reinforcers (beyond verbal praise) within antecedent and consequence-based strategies; and, 6) plans or considerations to reduce the intensity of identified behavioral interventions 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. It should be noted that since the last Monitoring report, improvements in many of the above areas were noted in some reviewed plans. For example, improvements in operationally defining replacement behaviors, including replacement behaviors in graphs and objectives, and attempts at identifying objective plan review criteria were noted in some plans. However, areas	Noncompliance

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		where limited progress appeared to be made and areas where the Facility should focus on improving included: 1) the conspicuous, robust, and systematic use of positive reinforcement, including the identification of reinforcers (other than verbal praise); 2) the history of prior interventions and outcomes; and, 3) the conspicuous use of strategies addressing setting events and motivating operations. Documentation provided revealed a new streamlined format for PBSPs. Although this new format offered a rubric that was highly likely to be found acceptable to both Psychologists and direct support professionals, the Monitoring Team's view of the new format was "cautiously optimistic." Indeed, it appeared much more concise and user-friendly than previous formats. However, Psychologists will need to ensure that all necessary elements central to behavioral programming are included. Consequently, elements that have been removed (rights restrictions, medications and side effects, etc.) will need to be documented and trained using other formats. If the Facility is able to demonstrate that these other necessary elements are adequately addressed through other means, then this new more streamlined PBSP format might offer significant utility. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the PBSPs, a subsample of plans were selected (from those identified above) and related approvals (specifically the BSC approval, Guardian consent, and Director approval) were examined during the onsite visit. This sample of consents included 10 individuals and represented approximately 71% of those PBSPs selected for off-site review and 7% of the total number of PBSPs currently implemented (N=140). These individuals are listed above in the documents reviewed section. Onsite documentation review revealed that nine (90%) of the ten individuals sampled had all of the necessary and current consents. The exception was the consent for Individual #184 that was obtained over 12 months ago. Of these, 90% of the PBSPs were implemented only after all the consents had been obtained. The exception was the PBSP for Individual #31 that appeared to be implemented (on 3/10/12) prior to the receipt of all the necessary consents (on 3/15/12). In addition, of those sampled, 70% were implemented within 14 days of receiving necessary consent. An examination of the most current Behavioral Services tracking grid, dated 3/7/12, indicated that 99 (71%) of all active PBSPs were implemented within 14 days of receipt of approval or consent. In addition, 115 (82%) received consent within 30 days of plan development. Recorded dates of BSC approval and/or expiration indicated that approximately 124 (89%) PBSPs had been reviewed and approved by BSC within the past 12 months. More specifically, at the time of the Monitoring Team's most recent visit, BSC approval and/or expiration dates exceed 12 months for 16 (11%) individuals with PBSPs. Lastly, review of the Behavioral Services tracking grid for Safety Plans for Crisis Intervention, dated 2/13/12, revealed that BSC approval expiration dates as well as the	

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		HRC expiration dates had exceeded 12 months for one (20%) individual with a SPCI (i.e., Individual #4).	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	As previously discussed with regard to Section K.4 of the Settlement Agreement, progress had been observed in the area of data collection and data review. However, although the collection of inter-observer agreement (IOA) data had continued since the Monitoring Team's last review, it was still unclear how this data was being summarized, analyzed and/or utilized. Previous reports have documented the Facility's efforts at collecting IOA data. The Monitoring Team's previous report noted that a total of approximately 53 IOA probes were completed across 11 residential sites. This reflected the completion of approximately 13% of the expected number of completed probes (during a three-month period). At that time, reported IOA estimates ranged from 77% to 100%. Currently, data revealed that 65 IOA probes were completed across 13 residential sites (between 10/14/11 and 2/29/12). Based on the verbally reported expectation that 10 IOA probes would be completed within each residence per month, this reflected the completion of approximately 11% of the expected number of IOA probes (during a four-month period). At the Monitoring Team's previous review, it appeared that a system had been developed to track IOA data collected over time by residence, unit, rater, and shift. At the current time, however, IOA data did not appear to be systematically monitored or examined using this system. More specifically, the previously provided summary excel sheet was not provided. Consequently, it was unclear if this data continued to be summarized, analyzed, and/or used in examining and improving the nature of data collection. Currently, data display within assessments and intervention plans was not evaluated, because verbal reports as well as documentation provided indicated that behavioral graphs would only be included in the PBSP progress note. This included the discontinuation of the monthly SPCI monthly progress note with the integration of restraint data within the monthly PBSP progress note. Documentation indicated that, starting 3/19/12, graphs presenting behavioral data would only be included in PBSP progress notes. Discussion of behavior data in other documentation would only include brief discussion of trends and summary of findings. To examine the nature of data display typically utilized to summarize, monitor, and review progress, a sample was selected and reviewed of 12 individuals with PBSPs who had an ISP meeting within the last six months. These individuals are listed above in the documents reviewed section. This review included the examination of Monthly PBSP Progress Notes over the last three months, as available. As described with regard to Section K.4, review of documentation indicated that all of the 12 (100%) individuals had	Noncompliance

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		Monthly PBSP Progress Notes completed across a number of consecutive months. In 10 of the graphs (83%), data for both target and replacement behaviors were displayed. That is, replacement behavior(s) were not included in the graphs in the progress notes for Individual #57 and Individual #31. Overall, it appeared that the revised Monthly PBSP progress note continued to facilitate effective graphic displays of data. This finding was consistent with observations noted during the previous review. However, some slight variability was observed in the quality of data display for some individuals. For example: 1) extra labels in the legend that did not appear related to data (e.g., Individual #6, Individual #31, Individual #57, and Individual #94); 2) the range of the Y-axis was too large and did not allow effective examination of data (e.g., Individual #116); and, 3) a second graph was included in the monthly note, but did not appear to illustrate meaningful data (e.g., Individual #31). In general, improvement in the quality of the Monthly PBSP Progress note continued to be observed. These improvements were similar with those noted 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 individuals to ensure effective and efficient data-based decision-making. This includes continued adherence to generally accepted graphing conventions. Although the quality of the monthly PBSP notes, including the use of adequate graphing conventions, appeared to continue to improve, the continued lack of systematic monitoring and ongoing analysis of IOA data negatively impacted the Facility's progress toward compliance with this provision. At this time, the Facility remained out of compliance with this provision.	
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.	Since the Monitoring Team's last visit, progress continued to be observed in ensuring that PBSPs were written so that direct support professionals could understand and implement them. Verbal reports and documentation revealed a continued emphasis on ensuring that PBSPs were written at or below a 6.9-grade reading level in an effort to increase the likelihood that direct support professionals understood and implemented them correctly. Readability levels of PBSPs continued to be assessed using Microsoft Word, and, when necessary, re-written to meet this criterion. Behavioral Services administrative staff appeared to closely monitor the readability level of PBSPs. At the current time, however, summary data of the readability estimates of all PBSPs was not provided so the estimates could not be confirmed. Documentation also revealed an ongoing effort to revise the format of the PSBP to increase its efficient development and effective utilization. More specifically, reports	Noncompliance

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		indicated that the most recent State Office draft format was utilized when revising the PBSP for Individual #190. However, reports from the Director of Behavioral Services indicated that staff did not find the new format any more acceptable than the previous format. Consequently, a more streamlined format was developed and several draft PBSPs were developed and implemented. Review of samples provided evidenced a significantly more concise format that resulted in lengths of one or one and one-half pages for most of the examples. The new format contained several content sections, including: 1) operational definitions of target and replacement behaviors; 2) the purpose, highlighting identified function(s); 3) objectives; 4) interventions; and 5) data collection procedures. In addition, the plan included an integrated scoring system for conducting competency/integrity checks. Indeed, this streamlined format was a dramatic departure from previous rubrics and necessitated the integration of information previously found in the PBSP into other documents. For example, historical information, behavioral data, risks and benefits, and psychotropic medications and side effects were no longer included in this new format. It should be noted that it had yet to be demonstrated whether this necessary information could be integrated successfully into other documents and used effectively. However, at the current time, this change appeared likely to reduce redundancy of information, as well as the efficiency with which plans could be developed and trained. The new format will demand that Psychologists strip their plans down to their essential elements. This appeared likely to produce an easier-to-read PBSP and a more user-friendly training document. The Monitoring Team's previous reports have described the process related to the completion of "PBSP Competency/Integrity Training" probes that LBSSLC utilized to measure competency and integrity of PBSP implementation. As observed in the Monitoring Team's last report, these assessments were completed a total of 335 times across all programs. However, it was noted that the majority of reported data 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 across the majority of residential programs. In response to these concerns, on 2/3/12, the format of this competency/integrity probe was changed to promote more direct observation and adequate completion, as well as to probe additional areas of competency (e.g., content related to restraint checklists). Currently, documentation indicated that between 2/3/12 and 3/16/12, approximately 125 competency/integrity probes were completed across all residential programs. Unfortunately, these probes did not produce a total score. Consequently, it was unclear how performance was accurately monitored. In addition, at the time of the recent review, verbal reports indicated that because the format was revised recently, no tracking sheet or summary data had yet been developed. According to the Director of	

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		Behavioral Services, in March 2012, summary data for treatment integrity was to begin being compiled and analyzed. Although the revision and completion of the competency/integrity probes demonstrated continued efforts to ensure treatment integrity, several concerns were currently noted. More specifically, several of the competency/integrity checks were completed inaccurately, because the inter-rater reliability item was incorrectly scored "C" across multiple probes (e.g., the seven probes conducted at Birch on 2/17/12 and 2/29/12, the probe conducted at Willow on 3/5/12, and the probes conducted at 514 on 2/28/12, 2/29/12, 3/12/12, and 3/13/12). This consistent error appeared to indicate that the raters did not closely read the items while scoring the probe. Consequently, this repeated mistake questioned the integrity with which the assessments were completed. In addition, inter-rater reliability had only been scored during nine (7%). Although the reliability estimates from these ratings appeared adequate (91.7 to 100%) the inadequate number of checks limited confidence in the accuracy of the assessment across all raters. In parallel to the revised PBSP format described above, a new more streamlined competency/integrity rubric was integrated into the PBSP in late February. This was a very recent revision, and no data on the use of this new format appeared to be available. Although seemingly more efficient by its integration within the PBSP, this new system appeared to be much more conservative by requiring a greater depth of knowledge and higher level of accuracy from direct support professionals. For example, on the previous form, direct support professionals were asked to provide the overall purpose, identify one function, identify one target and one replacement behavior, and identify a prevention procedure for one antecedent. On the new form, however, it appeared that staff would be required to know the identified purpose (at times, more than one), all of the target and replacement behaviors, all of the identified objectives, and all of the intervention strategies listed. Indeed, this new system "raised the bar," and required a deeper and more comprehensive understanding from direct support professionals in order for them to demonstrate competency on PBSPs. As reported by the Director of Behavioral Services, this new system will provide more robust and informative treatment integrity observations. Although this more stringent criterion appeared to be an improvement, concerns were noted regarding the new competency/integrity check. Unlike the previous version, the instructions appeared to be inadequate. Given the limited instructions, it was unclear whether verbal report and/or actual demonstration was required to demonstrate competency, especially on the intervention components. This new system will be examined more closely during the next Monitoring Team's visit.	
K12	Commencing within six months of the Effective Date hereof and with	Since the Monitoring Team's last visit, limited progress in the area of competency-based training was noted.	Noncompliance

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	full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	The Monitoring Team's previous reports noted changes in New Employee Orientation (NEO) training, as well as on-the-job-training (OJT). Since the Monitoring Team's last visit, verbal reports indicated no significant changes to NEO or OJT related to psychological services. However, verbal reports indicated that as changes had been made in systems (e.g., data collection), minor content revisions had occurred with regard to training. Verbal reports from Psychologists and Psychology Assistants indicated that the flexibility within OJT (as described in the Monitoring Team's previous report) of when training could occur had been helpful. However, more importantly, the amount of time to train direct support professionals, especially new hires, continued to be insufficient. For example, some verbal reports indicated that training was still limited to a four-hour window. With the number of plans at some residential programs, this appeared to be an inadequate amount of time to complete competency-based training. The Facility is encouraged to re-examine the amount of time allocated to training PBSPs, especially in residential programs with significant behavioral issues and/or those with higher number of PBSPs. The Monitoring Team's previous reports also highlighted the administrative oversight given to ensuring adequate attendance at mandatory trainings. This included informing direct support professionals that their attendance was mandatory, would be tracked over time, and would involve consequences for non-attendance. According to verbal reports from Psychologists and Psychology Assistants, this process had been very helpful in promoting attendance at trainings. Previously reported efforts to improve competency-based training Behavioral Services staff provided included a process of submitting videotapes for peer review. According to reports from the Director of Behavioral Services, this system was not sustainable once implemented and was discontinued. In February 2012, a subsequent process involving direct observation of training sessions by the Director and Assistant Director, and provision of performance feedback, if necessary, was initiated. Although it appeared that these sessions had been initiated, no data regarding the status of their completion or related findings was submitted for review. Previous recommendations had targeted the need to ensure that part-time or pulled direct support professionals received competency-based training. Documentation indicated that efforts had been initiated to provide and track the training that pulled staff received prior to working in programs. This documentation revealed that a new Pull Staff Member Orientation Page was initiated that would allow staff to track the training that was provided. Documentation indicated that this system was trained (in January) and implemented (in February and March) at only two residential programs (518 and 513 S. Cedar). It was unclear why this system was not incorporated at other residential	

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		programs, because the utilization of pulled staff appeared to be systematic practice. In addition, there was no documentation to indicate that the staff that provided the training to pulled staff had been judged to be competent trainers. As previously recommended, the Facility should ensure that, if utilized, trainers such as Residential Coordinators and Home Team Leaders have the necessary training competencies (i.e., similar to those currently expected from Behavioral Services staff) to adequately train pulled staff. As recommended in the Monitoring Team's previous report and recommended once again here, the Facility should ensure that key professional and support staff (e.g., Psychological Assistants, Home Team Leaders, Assistant Home Team Leaders, Residence Coordinators, QDDPs, etc.), who are most likely to be in positions to model accurate and effective programming (i.e., skill acquisition plans, PBSPs, SPCIs, data collection, etc.) to direct support professionals, are trained first. This group also could include "permanent floaters." Given the current nature of turnover and inconsistency in staffing, the Facility would greatly benefit from ensuring that the most reliable and experienced staff have the competencies to model and provide training and performance feedback to the many staff they support. According to recent reports from the Director of Behavioral Services, consultants from Texas Tech were to be involved in examining the nature of competency-based training for new hires (NEO and OJT), as well as current staff and permanent floaters. One of the issues that the Monitoring Team discussed with staff while on site was the need to have a methodology to track the staff who had successfully completed training on behavior supports, including the various phases or types of this training. Currently, the sheets with staff's signatures represented raw data that needed to be better captured and analyzed to ensure staff had the appropriate training to work with the individuals to whom they were assigned.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the recent onsite visit, in addition to the Director and Assistant Director of Behavioral Services, LBSSLC employed nine Associate Psychologists, and five Psychological Assistants. Of these staff, two Psychologists were currently BCBAs. At the time of the review, there were three openings in Behavioral Services Department. These openings included one vacant BCBA position, one administrative position, and one vacant Psychological Assistant position. Recent reports, as of 3/19/12, indicated that LBSSLC currently served 220 individuals. Based on this census, and the recognition that the Director and Assistant Director of Behavioral Services did not officially carry a caseload, an approximate average ratio of 1:25 Psychologist-to-individual served was determined. With five Psychological	Noncompliance

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		Assistants currently employed, the Facility exceeded the ratio of one Psychological Assistant for every two Psychologists/Associate Psychologists. The Facility was rated as being in noncompliance with this provision, 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 ensure the adequacy of required supervision according to the BACB supervision guidelines to eligible Behavioral Services staff. (Section K.1)
2. 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)
3. The Facility should continue to ensure adequate attendance by key members (e.g., psychiatry, nursing, etc.) at BSC meetings in accordance with established expectations (monthly attendance). (Section K.3)
4. The Facility should ensure that current written policies reflect current practice regarding internal and external peer review. (Section K.3)
5. In addition to utilizing an ongoing log to track the involvement of external supports (Texas Tech faculty and students, other professionals from other State Facilities), the Facility should more closely track and conspicuously discriminate between their involvement within critical peer review and consultative practices. (Section K.3)
6. The Facility should ensure that weekly and monthly notes are individualized, descriptive, and related to the data being displayed in an effort to provide meaningful analysis when trying to understand the nature of observed responding in relation to environmental contingencies. (Section K.4)
7. Psychologists should ensure that any collected and displayed data is identified and operationally defined. (Section K.4)
8. The Facility should ensure that progress is being made in updating psychological assessments. This includes supporting the two identified psychometricians that have been identified to update standardized tests of intelligence and adaptive behavior. (Sections K.5 and K.6)
9. The Facility should ensure that the rationale for revisions of SFARs and PBSPs are conspicuous, especially when assessments and interventions are re-evaluated and revised promptly when target behaviors do not improve or have substantially changed. (Sections K.4, K.5 and K.9)
10. It appeared that the majority of assessments, including SFARs, were reviewed and revised in correspondence with ISP meetings. The Facility should ensure that assessments that are revised due to continued maladaptive responding are conspicuously identified within ISPs and other documentation.
11. With regard to counseling sessions, the previous recommendations still apply:
    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 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. Community-based therapists should continue to be provided support in writing measureable goals/objectives.
    c. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness

(or lack thereof) of the recommended practice. The determination of the effectiveness of counseling should be data-based.

d. 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. If not already completed, the Facility should identify potential barriers to provision of these services and develop potential solutions. (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. Although progress in PBSPs continued to be observed, areas in need of improvement continue to include:
    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 progress determination, especially for identified replacement behaviors;
    d. Data display, including baseline data, especially for replacement behavior(s);
    e. Conspicuous integration of robust reinforcers (beyond verbal praise) within antecedent and consequence-based strategies; and,
    f. Plans or considerations to reduce the intensity of identified interventions. (Section K.9)
14. The Facility should 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)
15. The Facility should ensure that revised PBSPs continue to contain necessary elements (i.e., prevention strategies targeting setting events and motivating operations). If content previously found with PBSPs is removed, Psychologists should ensure that this information remains conspicuous and is meaningfully included in PBSPs or related documents. (Section K.9)
16. The collection of inter-observer agreement (IOA) data should be expanded. This includes continued use of the developed tracking system to ensure adequate collection across probes across residences, raters, and shifts, for example. (Section K.10)
17. As previously recommended, the Facility should consider the following as it revises its graphing procedures within progress notes:
    a. Ensure that the vertical (Y) axis is of sufficient range to adequately allow effective interpretation of the included data;
    b. Ensure that all legends markers are identifiable when integrating graphic displays into documents; and
    c. Remove additional legend markers if not in use. (Section K.10)
18. The collection of PBSP competency/integrity training assessments should continue and expand, including inter-rater reliability assessments estimates. In addition, the Facility should develop a tracking sheet to assist with ongoing monitoring and analysis. (Section K.11)
19. The Facility should re-examine the amount of time provided to training new staff on behavioral programming and ensure that the amount of time is adequate given the expected outcome of the training. (Section K.12)
20. The Facility should ensure that staff members (i.e., Behavioral Services staff as well as Home Team Leaders, Assistant Home Team Leaders, etc.) who have been identified to provide competency based training to relief or pulled staff are competent to do provide the training. This should include the use of a standardized rubric to ensure consistent assessment and adequate competency across observed staff. (Section K.12)
21. The Facility should consider developing a system to track the competency-based training of all direct care and supervisory staff, including pulled, part-time staff, or relief staff. This system might be a helpful when trying to identify pulled staff to work in select residential programs. (Section K.12)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: o **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all primary care providers that are new to Facility since last monitoring review; o Number of individuals on each physician's caseload; o Employees listed under Medical Department completing Cardiopulmonary Resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Copy of any in-service training for PCPs on International Classification of Diseases (ICD) and Diagnostic Statistical Manual (DSM) diagnostic criteria in last six months; o Since the last onsite review: a) copy of CMEs for each primary care provider; b) list of CME credits according to topics reviewed; c) list per PCP of total CME credits during this time period; o Since the Monitoring Team's last visit, any clinical guidelines developed and implemented; o Minutes of infection control committee meetings during the prior six months; o Minutes of skin integrity committee meetings during the prior six months; o Most recent results/reports of the medical quality improvement program, including identification of trends and descriptions of actions taken toward improvement; o For any medical staff meetings (morning provider meetings), copy of all minutes, handouts, logs from hospitalizations, and 24-hour reports discussed, for 15 days prior to the Monitoring Team's visit; o Since the Monitoring Team's last visit, most recent results/report of the facility-wide medical review system, including copy of any non-facility physician review reports or data; o For individuals that had died since last visit, date of death, autopsy report, and medical documentation for seven days prior to death; 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 DNRs; o Current DNR list with reason/criteria for DNR; o List of outstanding clinical/administrative death reports; o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination: Individual #37, dated 12/23/10, 12/19/11; Individual #222, dated 1/13/11, 1/12/12; Individual #100, dated 2/4/11, 1/6/21; Individual #314, dated 1/11/11, 1/31/12; Individual #306, dated 12/16/10, 1/13/12; Individual #147, dated 1/27/11, 1/18/12; Individual #66, dated 12/23/10, 1/5/12; Individual #296, dated 1/11/11, 1/6/12; Individual #270, dated 12/23/10, 1/4/12; Individual #176, dated 1/1/11, 12/29/11; Individual #113, dated 12/14/10, 12/15/11; Individual #13, dated 3/1/11,1/26/12; Individual #174, dated 11/4/10, 12/28/11;

	Individual #324, dated 1/26/11, 1/26/12; Individual #310, dated 12/14/10, 1/13/12; Individual #80, dated 1/4/11, 1/3/12; Individual #263, dated 12/23/10, 1/25/12; Individual #28, dated 3/3/11, 1/23/12; Individual #272, dated 12/28/10, 12/8/11; and Individual #215, dated 1/10/11, 1/27/12; o Specialty clinic schedule per month, for past six months; o List of all outside consultations for medical purposes, for the past six months; o List of individuals with: a) tracheotomies; b) Vagus Nerve Stimulators (VNS), including date of VNS placement, and, if applicable, replacement date; c) fractures, date of fracture, type of fracture (compound, simple, stress, etc.), and bone fractured (location); d) injuries requiring visit to Emergency Room (ER) or hospitalization, since the last on site review, and; E) pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last on site review; o Policies and procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, and list reason for colonoscopy (preventive versus evaluation of active problem), with reason if not up-to-date; o For women over 40, date of last mammogram and reason listed if not up-to-date (guardian refusal, etc.); o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person [include calcium, Vitamin D, intravenous (IV) bisphosphonate, etc.], and date of last Dual Energy X-ray Absorptiometry (DEXA) scan or state none completed; o Most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For individuals with Down's syndrome, date of last thyroid test; o For the 10 individuals who most recently went to the ER, copies of integrated progress notes from start of signs/symptoms to transfer to ER, and ER reports, including those for: Individual #70, Individual #6, Individual #161, Individual #94, Individual #171, Individual #125 (1/23/12, and 1/26/12), Individual #182, Individual #62, and Individual #128; o For those going to the ER and not hospitalized, copy of discharge orders from the ER, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations), including those for: Individual #70, Individual #6, Individual #161, Individual #94, Individual #171, Individual #125 (1/23/12, and 1/26/12), Individual #182, Individual #62, and Individual #128; o For those admitted to the hospital, copy of admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, for the 10 individuals most recently hospitalized that have returned to the Facility for at least 30 days (in order to allow completion of recommendations): Individual #211, Individual #161, Individual #155, Individual #62, Individual #242, Individual #316, Individual #128, Individual #51, Individual #192, and Individual #89;

	o For 10 most recent hospitalizations that have been completed, the Hospital Liaison Nurse documentation, including for: Individual #211, Individual #161, Individual #155, Individual #62, Individual #242, Individual #316, Individual #51, Individual #192, Individual #128, and Individual #89; o Length of stay for Infirmary admissions, for past six months; o Infectious disease data per quarter by category of infection, for last two quarters; o Any summary report or trend analysis of infectious disease/communicable disease, for the last two quarters; o Avatar pneumonia tracking forms, for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia; b) decubitus ulcers; c) Urinary Tract Infections (UTIs); and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer) for past year for individuals who have been newly diagnosed with: a) malignancy; b) cardiovascular disease; c) diabetes mellitus; d) sepsis; e) bowel obstruction or bowel perforation; and f) pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including name of individual, residence/home, diagnosis (type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #74, Individual #290, Individual #171, Individual #114, Individual #120; o List of individuals seen by neurologist with dates seen and reason, since the Monitoring Team's last visit; o List of those with status epilepticus, since the Monitoring Team's last visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged/new onset seizure, since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for VNS placement and the stage of evaluation; o Percentage of individuals on one, two, three, four, and five antiepileptic drugs (AEDs); o Percentage of individuals on older AEDs (Phenobarbital, Dilantin, Mysoline); o Any tracking of data for individuals who have transitioned to community in the past year, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided; o For the last five individuals in whom pre-treatment sedation was administered, all

	information related to medical/dental pre-treatment sedation used prior to visits, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries for: Individual #183 on 2/1/12, Individual #314 on 1/31/12, and 2/23/12; Individual #60 on 2/23/12; and Individual #298 on 2/16/12; o The four most recent Community Living Discharge Plans developed, including the individuals' ISPs, and related assessments that were used in the development of the CLDP and/or were considered to be the required 45-day assessments, attendance/signature sheets, and any further documentation of the Facility's efforts to ensure the individual and the family/LAR was informed of the contents of the CLDP for Individual #48, Individual #173, Individual #166, and Individual #134; o Any communication to community Service Coordinator/equivalent at transition at end of 90 days (from the last visit); o CMEs for PCPs Rodriguez and Thomas; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o Resuscitative status definitions for Level I, II, and III; o List of women age 40 and over with birthdates; o List of all individuals age 50 and over with birthdates; o February 2012 Specialty clinics; o Autopsy report for Individual #118; o Since the Monitoring Team's last visit, post-move monitoring information (seven-day, 45-day, 90-day), and other notes as applicable; o 10 most recent PNMT recommendations with physician orders; o February 2012 external and internal audits; o August 2011 external audit; o DG-1; most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past year of any IPN pages with PCP entries; past year of labs, x-ray reports, scans, Magnetic Resonance Imaging reports (MRIs), and ultrasound reports; hospital discharge summaries for past year; ER reports for the past year; consults and procedure reports for the past one year; DNR form if applicable; physician orders for the past year; most recent ISP and subsequent addendums; most recent PBSP; most recent integrated risk rating form including attendance roster; and most recent risk action plans for following individuals: Individual #52, Individual #276, Individual #204, Individual #6, Individual #203, Individual #74, Individual #34, Individual #23, Individual #17, Individual #111, Individual #113, Individual #269, Individual #143, Individual #298, Individual #324, Individual #315, Individual #198, and Individual #84; o Documentation for closure on "dislodged G tubes [Gastrostomy Tube];" o State's response to request for copy of Quantros reports past six months; o ISP addressing refusal of colonoscopy for Individual #222; o Number of employees as or 3/12/12, and number of those who have received flu vaccines;

	o IPNs, lab physician notes, x-rays from 7/1/11 to 9/7/11, Hospital Liaison notes from 9/7/11 to 11/16/11, active problem list, and most recent annual medical exam for Individual #72; o IPNs, lab, physician notes, x-rays from 9/1/11 to 1/27/12, active problem list, annual medical exam, and Hospital Liaison notes from 1/27/11 to 2/22/12 for Individual #41; o IPNs, lab, physician notes, x-rays from 9/1/11 through 10/3/11, active problem list, annual medical examination, and Hospital Liaison notes from 10/3/11 to 11/10/11 for Individual #118; o Copy of 3/21/12 letter regarding Individual #263; o ISPA addressing missed mammograms and gynecology appointments for Individual #119; o ISPAs addressing missed appointments or refusals for the past three months; o List of database/monitoring tool data that were put on hold since Medical Compliance Nurse leave, and databases that need to be completed, including the monitoring indicators; o Dates of the last two completed annual medical assessments for all individuals; o Dates of the last two completed quarterly medical reviews; o Individuals with VNS with placement date; o List of individuals with seizure diagnosis not currently prescribed anti-epileptic medications; o List of missed medical appointments with reasons past six months; o Ethics committee meeting minutes, since Monitoring Team's last visit; o LBSSLC: List of individuals by name, dated 3/14/12; o Hospitalizations; and o Presentation Book for Section L. o **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; o Resurreccion Barranda, MD, Staff Physician; o Ricardo Rodriguez, MD, Staff Physician; o Grazyna Thomas, PA-C, Staff PCP; o Melody Morton, RN, Clinic Manager; o Dawn Ripley, QA Director; o Carla Prell, Admissions/Placement Coordinator; o Annette Webster, Post-Move Monitor; and o Jim Forbes, Director of Behavioral Services. o **Observations of**: o Individual #323, Individual #258, Individual #37, Individual #312, Individual #217, Individual #136, Individual #6, Individual #195, Individual #293, Individual #181, Individual #281, Individual #17, Individual #211, Individual #225, Individual #176, Individual #283, Individual #304, Individual #104, Individual #167, Individual #196, Individual #191, Individual #62, Individual #139, Individual #324, Individual #185, Individual #21, Individual #29, Individual #215, Individual #78, and Individual #89; and o Morning provider meetings, on 3/20/12, 3/21/12, and 3/22/12.

	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating summary. Additionally, the "Provision Action Information" with recent updates, provided an outline of compliance steps taken per subsection. Although a number of concerns continued to exist with the Facility's Self-Assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. According to the Self-Assessment, the Facility had made progress in providing medical care to meet the needs of the individuals. The Medical Department determined that 82% of the annual exams occurred in a timely manner, and 53% of the medical quarterly reviews were timely. Based on the self-assessment data, 71% of those for whom a mammogram was recommended received this test, and 83% of those for whom a screening colonoscopy was indicated had received one. According to the Facility, those with resuscitative status II were up-to-date. August 2011 medical peer review corrective action plans were 97.7% complete, and November 2011 medical peer review corrective action plans were 85% complete. However, the Monitoring Team's findings did not confirm some of the above findings. Based on its review, the Monitoring Team found that 51 to 55% of annual medical assessments were completed in a timely manner. From the submitted data, 26% of medical quarterly reviews were done in a timely manner. However, no medical quarterly review was submitted for any of the medical record reviews. The rate of mammogram completion was 74%, similar to the Facility's review results. The Rate of colonoscopy completion was 86%, again similar to the Facility's review results. There was one individual with a Resuscitative II order who was not up-to-date. In the last quarter of 2011, the Medical Compliance Nurse had created a number of databases, and had plans for several others. The unexpected prolonged leave of this staff member had not allowed the Medical Department to monitor and analyze all the areas originally planned. There was no data concerning missed appointments or refusal of appointments. The database for osteopenia/osteoporosis had problems with lack of entry of calcium and Vitamin D into the treatment section. The database did not appear to reflect the actual comprehensive treatment of osteoporosis provided at LBSSLC. In its Self-Assessment, the Facility noted that the February 2012 medical peer review had included a medical management component. This was a positive addition. However, the external and internal medical peer review data had been combined, which made it less useful than if the two sets of data were separated. In addition, the Facility's Self-Assessment only provided overall completion rates in relation to corrective action plans implemented as a result of these reviews. It would have been more helpful to identify data for specific indicators from the tools, or to identify trends from the data to guide the Facility's assessment of its status, and to assist in identifying areas in need of attention. The State Office recently had developed a number of clinical algorithms and guidelines. The Facility had adopted them as policies and procedures. However, there was no information to suggest that these had been reviewed or implemented, or that clinical indicators had been extracted from them to measure the

	Facility's success with regard to the provision of appropriate treatment. The concerns raised at the morning provider meeting were being tracked until closure. However, the Facility did not include data in its self-assessment concerning the percentage that remained unresolved, or the number that resulted in an appropriate ISPA. There was no mechanism for the resulting ISPA to be reviewed at the morning provider meeting, or recorded in a database. Overall, the Facility's Self-Assessment data did not adequately address the quality of the medical services provided. The Self-Assessment largely related to timeliness, and not, for example, to the quality of the content of medical assessments and quarterly reviews, closure of issues identified, or adherence to clinical guidelines. As the Monitoring Team has done, the Facility will need to include both quantitative as well as qualitative measures in its self-assessment activities. In its Self –Assessment, the Facility indicated that it was not compliant with Section L. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Facility continued to make progress with this section of the Settlement Agreement. The Medical Department had a complex, but user-friendly medical database system. From this data, the Department was able to track ER visits and hospitalizations, determine trends, investigate causes, and implement plans that had positive impact on quality medical care at LBSSLC. As noted above, this information was not adequately integrated into the Facility's Self-Assessment. The morning provider meeting continued to be a forum for integrated medical care management. There was a consistent interdepartmental presence. The meeting continued to be the conduit for reporting health status change to the QDDP by way of the Nursing Department representative at the morning meeting. Closure was tracked via a worksheet. However, although some discussion occurred at morning meetings regarding closure, it was unclear how this information was routinely reconciled. For example, it was not clear if the tracking sheet was reviewed routinely with providers to determine and address outstanding issues. In addition, there was a continued need for the group to focus on preventing recurrent hospitalizations and adverse events. Concerns routed to the QDDP and then to the IDT were not tracked to determine if the team met, as appropriate, and when necessary, an ISPA was created and implemented. As noted above, the Monitoring Team's review identified problems with the timely completion of annual assessments and evaluations, as well as the completion of quarterly reviews. In addition, based on data the Facility provided, some of the preventative evaluations (e.g., mammography, vision, and audiological screening) were not being completed timely and consistently for individuals. In addition, LBSSLC did not have an adequate system in place to track the reasons for missed appointments, and address the underlying causes. Some of these appeared to be systems issues, while others would require individuals' IDT to be involved in addressing the issues. Those individuals with a DNR status needing annual renewal appeared to be up-to-date in most cases. The external and internal peer review processes were completed together. Unfortunately, the data could

	not be separated. A new area the audit covered was medical management of select diagnoses. This was included in the February 2012 external review. However, a synopsis of the February audit was not available. The QA Department tracked the corrective action plans of prior audits to completion. A few incomplete corrective action plans remained. Although the Facility was up-to-date on its clinical death reviews, no information was available to confirm implementation of the recommendations from the various types of death reviews. In fact, it was not clear that the Facility had a process in place to determine agreement on the death review recommendations, and then ensure adequate follow-through occurred.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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 (DNR) Orders. <u>Staffing and Administration</u> Information the Facility submitted concerning PCPs' caseloads was dated 2/14/12. According to the total caseload of 221 at that time, the Medical Director had a caseload of 15 individuals. The Physician Assistant had a caseload of 72 individuals. One Staff Physician had a caseload of 65, and the other Staff Physician had a caseload of 69. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated 2/7/12. Of the primary care providers in the Department, four out of four (100%) were current in CPR. Additionally, the Medical Compliance Nurse and the Clinic Nurse were current in CPR. However, several personnel in the Medical Department with clinical responsibilities were not listed, including the Respiratory Therapists, as well as lab and radiology technicians. The Facility should ensure documentation is maintained of current CPR certification for all clinical personnel. Of the four PCPs in the Medical Department, a list of CME credits was submitted for all four of these PCPs. This varied from 14 to 25.50 hours for three of the PCPs. The list of CMEs for one PCP did not include any in the prior six months, although the listing was difficult to interpret. However, that PCP had adequate CME during the prior six months. The topics that were covered included a wide range of primary care topics, such as trauma, critical care, dysphagia management, community hematology, managing the risk of sudden cardiac death in nonischemic patients, bone turnover markers, Huntington's	Noncompliance

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		chorea, glucocorticoid drugs associated with neuropsychiatric illness, fever of unknown origin, colorectal cancer screening, 24-hour control of blood pressure, Type 2 diabetes mellitus, oral anticoagulant therapy in thromboembolic disease, dyskinesia in Parkinson's disease, noncardiac chest pain, among many others. All topics were considered valuable for primary care and provided appropriate knowledge base for care of the population at LBSSLC. The Facility's information system should include the CME topics per date completed per PCP, to ensure each course or topic is counted only once. Additionally, several of the CME submissions only included the conference title and did not provide content of topics covered. The system the Facility uses to track CMEs should include the topics covered at the conferences. <u>Physician Participation In Team Process</u> Recording of the minutes for the morning provider meeting had been streamlined to approximately one page, and this was in a narrative format. As the Monitoring Team observed, closure items were discussed at the morning meetings, but it was not clear how these were logged in the morning provider minutes. In the narrative section, there was a section for closure updates. However, it appeared the closure information was accumulated, and entered into a table format at periodic intervals. One table of closure follow-through was included at the end of the 1/4/12 morning provider meeting minutes. Another table of closure concerns was dated 2/8/12. A subsequent table was submitted entitled: "Morning Provider Meeting Minutes on Closure Items," dated February 29, 2012. This last document provided a concise approach to tracking closure concerns, including topic, date of initial discussion, responsible person, action steps, closure date, and resolution briefly described. This provided the Medical Director with a user-friendly view of the current status of closure items. However, it was not clear if this document was a medical administrative document (worksheet), or part of the morning provider minutes that might have been discussed at intervals. There was no information to determine if this was part of a periodic meeting to finalize closure concerns or an administrative document only. The frequency of review or discussion of these tables or creation of tables could not be determined. In its response, the State indicated that this document was part of the morning provider meeting and was "discussed routinely." However, what "routinely" meant was not defined. The Monitoring Team will obtain further clarification during the next onsite review. It did appear that items were followed until closure. If a closure table were reviewed periodically, this would help to ensure all outstanding issues were provided closure in a timely manner. The content was of value to the Medical Department, and, if not already part of the process, this information should be shared at a medical staff meeting and/or the morning provider meeting. Documenting a formal procedure for follow-up to items requiring closure would be helpful to both the Medical Department and the Medical Compliance Nurse, who was	

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		responsible for documenting this process. As noted above, based on the Monitoring Team's review of documentation, extensive additional documentation of closure concerns/topics was available in minutes dated 1/4/12, 2/8/12, and 2/29/12, but not on other dates during this time period. This suggested intermittent reviews were conducted with the Medical Department and morning provider meeting attendees. This appeared to be a separate process because it was documented at approximately four-week intervals. If there was daily rather than periodic four-week discussion of items that had been closed and discussion of items not closed, then further clarity in a written policy/procedure/protocol and expectations regarding the morning provider meeting minutes would provide needed clarification. The agenda of the morning provider meeting followed a routine pattern, starting with the on-call physician reviewing telephone communications and any onsite activities. The PCPs on campus that day also addressed other significant clinical concerns from the prior business day. Medical concerns listed in the Campus Coordinator log also were discussed. This was followed by a review of hospitalized individuals, and a review of any consultation reports the PCPs had received and reviewed. Chemical restraint use also was reported. During the Monitoring Team's visit, pre-treatment sedation usage was discussed for specific individuals, and psychiatry provided a summary of orders recommended. Although during the Monitoring Team's visit, no emergency chemical restraint was reported at the morning provider meeting, a review of prior minutes indicated they were reviewed at this meeting. Specialty clinics to be held on site that day also were announced. Data should be collected to reflect the activity of the morning provider meeting, such as the number of closure concerns identified per month, the number of closure concerns resolved with documentation per month, the number of closure concerns outstanding/unresolved per month, the number of recommendations made to the IDTs, and the number of ISPAs created that incorporated the recommendations and concerns identified through the morning provider meeting. This would provide tracking of the morning provider meeting concerns to completion, and provide a path of accountability for the IDTs to address clinical concerns in a timely manner. The above-mentioned closure flow sheet contained much of the needed information, and if completed accurately and completely, could be a resource in these analyses. During observation of the morning provider meetings of 3/20/12, 3/21/12, and 3/22/12, there were some concerns for which follow-up was addressed, providing documented closure. These included follow-up of a diet change, and separately, a follow-up of a urological concern. A review of the submitted minutes demonstrated the morning meeting also was utilized	

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		as a forum for interdisciplinary discussions on clinical topics important to the individuals residing at LBSSLC. As an example, the 1/4/12 minutes documented a discussion concerning ways to prevent aspiration pneumonia. However, each hospitalization, ER visit, and other adverse/sentinel event should be discussed at the morning meeting with critical thinking documented concerning prevention of recurrence. Based on the discussion, it would be expected that one or more closure items (e.g., more information, plans made, supplies ordered, consult or testing to be ordered upon return, etc.), would be identified for each of these events. It would be expected that these actions would be especially focused on prevention of recurrence. However, in tracking a number of hospitalizations and ER visits, closure concerns or action steps could not be identified for each. If there were no closure concerns or further preventive steps (which should be the minority of cases), then this should be documented. <u>Routine Care</u> The Facility submitted a list of dates of the last two completed annual medical assessments for all individuals residing at LBSSLC. The list included 211 names, which was slightly less than the current census. Additionally, incomplete information was provided for nine individuals (i.e., only one date listed with no reason submitted, such as new admission, or the dates suggested a database entry error). This left 202 individuals for which information could be analyzed. Of these 202 individuals, annual medical assessment had been completed within 365 days of the prior assessment in 103 out of 202 (51%). For 20 individuals, 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. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. By reviewing the more recently completed annual assessments, a determination could be made regarding whether the Facility had made progress with regard to the timely completion of these assessments. For the 20 individuals, compliance was 11 out of 20 (55%). As part of the monitoring review process, the Monitoring Team selected the medical records of 18 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. For twelve individuals, every 18th name on the census list was selected, after the first name was chosen by random selection. Additionally, six individuals considered to be at high risk for one or more risk categories were also selected. Documents reviewed included the preventive care flow sheet, physician orders for the past year, integrated progress notes for the past year, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays reports, scans, MRI, ultrasound reports, consult forms, and procedure reports from	

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		the past year, the most recent health management plan, the most recent annual medical assessment and physical exam, the DG-1, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and DNR status, if applicable. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From 18 medical records reviewed: ▪ Thirteen of 18 (72%) annual medical assessments had been completed in a timely manner. For the five records that included out-of-date annual medical assessments, the IPN in four indicated the document had been completed. However, it was not available for undetermined reasons. The Facility is encouraged to review the timely filing of annual medical assessments. The lack of current annual medical assessments has the potential to hinder quality care by all disciplines. ▪ Active problem lists appeared to be thorough in 12 of 18 (67%). ▪ Fourteen of 18 (78%) had information about smoking history. ▪ Seven of 18 (39%) had information discussing requirements for transition. However, it was noted that important information was not included in this section to ensure potential successful placement. It is recommended that the Medical Department review the essential components that should be included in this section. Generalizations should be replaced with specific steps that can be planned and implemented as part of a transition plan. ▪ The DG-1 forms were reviewed. Of the 18 DG-1 forms reviewed, 11 (61%) had updated diagnoses. The DG–1 form did not provide ample space for listing many of the diagnoses for Axis III. The entries chosen might not be the most important or critical diagnoses for the individual. When space is limited and a choice of which diagnoses to enter, the PCPs should provide guidance to the staff that complete the medical coding for the entry of the most significant diagnoses. The 18 medical records also were reviewed to determine whether the physician IPN notes used the SOAP format. In 18 of 18 (100%), the SOAP format was used, and included date and time on the IPN. The Facility submitted a list of the dates of the last two completed quarterly medical reviews for all individuals. The dates of the most recently completed quarterly were reviewed to determine if completion occurred within 90 days of the prior quarterly medical review. The names of 221 individuals were submitted. Of these, 57 (26%) had timely completion of the quarterly medical review. None of the 18 medical records (0%) had a PCP quarterly review of medical progress during any quarter in the prior year. This appeared to be a discrepancy with the list of	

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		dates of current and prior quarterly medical assessments. That there were none submitted might indicate they were not completed, or that they were not filed, or that they were filed in a section of the active medical record that was not copied and submitted for review. With the assumption that they were included in a specialized IPN note and should be located in the IPN section, it was problematic that none of the 18 records had a current or prior quarterly medical assessment for any time in the prior year. <u>Access to Specialists</u> The Facility had access to all medical and surgical specialties available in the community. There did not appear to be concerns with access to needed specialties at the appropriate time in treating individuals residing at LBSSLC. The following numbers of off–site visits for consultation or procedures were documented for the time period from July 1, 2011 to February 1, 2012: ▪ Allergy – four appointments; ▪ Allergy and asthma – 11 appointments; ▪ Audiology – five appointments; ▪ Cancer Center (including mammograms, DEXAs, ultrasounds, and other diagnostic studies) – 129 appointments; ▪ Cardiology – 32 appointments; ▪ Dermatology – nine appointments; ▪ ENT – 17 appointments; ▪ Family medicine – seven appointments; ▪ General surgery/surgery - 56 appointments; ▪ Gastroenterology – 171 appointments; ▪ Gynecology – four appointments; ▪ Hematology – 28 appointments; ▪ Internal medicine – two appointments; ▪ Nephrology – 17 appointments; ▪ Neurology – 16 appointments; ▪ Oncology – 10 appointments; ▪ Ophthalmology – 33 appointments; ▪ Orthopedics – 13 appointments; ▪ Orthotics – two appointments; ▪ Psychiatry – two appointments; ▪ Pulmonology – 15 appointments; ▪ Radiology – 88 appointments; ▪ Rheumatology – two appointments; ▪ Sleep studies – four appointments; ▪ Urology – 30 appointments; and ▪ Wound specialist - 12 appointments.	

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		On site, several specialty clinics were held to meet the needs of the individuals. From September 1, 2011 through February 29, 2011, the following specialty clinics were held on site: ▪ Vision clinic - seven clinics (i.e., 9/2/11, 10/7/11, 11/10/11, 12/2/11, 1/13/12, 2/3/12, and 2/24/12); ▪ Endocrinology clinic - six clinics (i.e., 9/29/11, 10/27/11, 11/30/11, 12/22/11, 1/31/12, and 2/29/12); ▪ Neurology clinic – 16 clinics (i.e., 9/7/11, 9/9/11, 9/21/11, 10/5/11, 10/14/11, 11/2/11, 11/18/11, 12/7/11, 12/9/11, 12/21/11, 1/11/12, 1/25/12, 1/27/12, 2/8/12, 2/17/12, and 2/22/12); and ▪ Podiatry clinic – six clinics (i.e., 9/21/11, 10/19/11, 11/16/11, 12/21/11, 1/25/12, and 2/22/12). The Facility submitted a list of missed medical appointments for October 2011 through February 2012 for offsite consultation appointments, with reasons. A total of 78 of the 221 individuals residing at LBSSLC (35%) were identified as having had a missed appointment. Reasons provided included: no consent – 19; behaviors – 21; cancelled by consultant - 21; illness or hospitalization – 16; pre-visit labs, medication, or preparation not provided or insufficient – 13; inclement weather – one; schedule conflict – one; moved to community – three; furlough - one; lack of Medicaid number – one; various administrative issues – 25; and unknown - eight. Some of these indicated the need for improved communication. Systems to ensure appropriate preparation for the visit (e.g., consent, preparation, pre-med given, or need for pre-med, etc.) also potentially would have had a positive impact on reducing missed appointments. Some of the missed appointments due to the consultant cancelling the appointment or some of the administrative reasons indicated the need for improved communication, or that the appointment was rescheduled earlier, and the category of missed appointment might not have applied. It is recommended the Medical Department review the missed off -site consultation appointments, with the goal to reduce the numbers of individuals missing appointments, as well as the rate of missed appointments. For the onsite clinics, 42 appointments were missed during the months of December 2011 through January 2011. Behaviors were the reason given for 17 of these, and for 14 (33%) of the missed appointments, no reason was provided. It is recommended that the Medical Department continue to track missed appointments for onsite specialty clinics, and increase the percentage of those for which the reason for missed appointments is documented, and using this information, begin to reduce the numbers of missed appointments. The Department had only submitted two months of information, and any trend in improvement would require several months of information. This appeared to be a good baseline of information from which future progress could be determined.	

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		One ISPA was submitted for an individual that refused a specialty appointment. This was initially discussed at the morning provider meeting, followed by referral to the IDT. There was background information in the ISPA, as well as a series of recommendations that involved the participation and coordination of several departments. This ISPA (for Individual #119) indicated thoughtful integration of ideas to assist the individual to successfully complete the specialty examination. However, the Monitoring Team made two requests onsite for follow up ISPAs for missed appointments. One was specifically for this individual, but a second request included the ISPAs for those that refused appointments in the prior three months. It was not clear if that was simply misinterpreted, or if this was the only ISPA that reflected a team approach to refused appointments. For those with behavioral issues that impede their ability to attend appointments, IDTs should meet, and meeting minutes should document the teams' decisions related to amending the ISP or the BSP, if applicable. This might also indicate the need for desensitization or other programs to improve compliance with attendance. It might indicate the need for improved systems of communication with the direct support professionals and residential management staff. For another individual (i.e., Individual #222), a colonoscopy had been attempted or rescheduled three times. No information was provided on the data sheet regarding the reason for the inability to complete the colonoscopy. A copy of the ISP, dated 1/26/12, only indicated that the physician would schedule the procedure within the next 30 days. No discussion was recorded regarding the reasons for the prior failed attempts, or steps the team was taking to ensure success when the procedure was rescheduled. There was no indication that the team had implemented any change that would allow for successful test completion. There also was a nine-month lapse of time between the attempts at a colonoscopy, and any follow-up information provided to the team or response from the team. A system should be put in place, possibly involving the QA Department, to monitor missed appointments, including the quality of the team discussion, decisions, and corrective action plans. The Facility submitted information for pre-visit sedation for medical visits/procedures. Information was provided for four individuals undergoing five pre-treatment sedations. Reasons for the medical visit included an MRI of the head and sinuses, a mammogram, an Ear Nose Throat (ENT) consult, a vision consult, and an annual physical examination. The following summarizes the results of this review: ▪ Consent was submitted for three of the five pre-visit sedations (60%). ▪ There was no sedation care plan submitted or restraint checklist completed for any of the five pre-visit sedations administered (0%). ▪ HRC approval was submitted for three of the five pre-visit sedations (60%). ▪ Vital signs were recorded prior to the procedure in two of five records (40%).	

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		The Medical Department should ensure appropriate documentation is maintained in the active record before and during administration of pre-visit sedation. <u>Preventive Care</u> The 18 medical records were reviewed to determine completion and timely updating of the "Preventive Care Flow Sheet." Twelve of 18 medical records (67%) reviewed had current information recorded on these forms. Current vision screening was documented in 14 out of 18 records reviewed (78%). Audiological screening was current in 10 out of 18 records reviewed (56%). The influenza vaccination had been given to 18 of 18 individuals (100%) in a timely manner during 2011-12. 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 17 of 18 active records (94%). Hepatitis B vaccine or immunity was documented in 17 of the 17 active records reviewed (100%). One individual was a hepatitis carrier. The Medical Department indicated it kept a database for tracking of DEXA scan completion, mammograms, and colonoscopies. A list was submitted identifying women residing at LBSSLC over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. A total of 49 women were identified as being over the age of 40. In a policy from DADS entitled: Preventive Health Care Guidelines: SSLCs, dated 8/30/11, there was a recommendation for breast cancer screening for individuals with developmental disabilities. The expectation in the SSLCs was that an attempt would be made at annual mammography screening for women ages 40 to 70 years. This recommendation was used as guidance in reviewing compliance with mammogram completion. Of the 49 women over age 40, seven had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, medically not indicated, age beyond 70 years, etc.). Of the remaining 42 eligible women, 31 had mammograms within the prior year. This was a compliance rate of 31 out of 42 (74%). From the sample of 18 medical records reviews, there were four females between the ages of 40 and 70. Of these, the guardian refused consent for one individual. Of the eligible three individuals, three of three (100%) were up-to-date on mammogram testing.	

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		From the sample of 18 medical records reviewed, there were six males age 50 or greater. Of these five (83%) had a Prostate-Specific Antigen (PSA) test in a timely manner. The policy from DADS entitled: Preventive Health Care Guidelines: SSLCs, dated 8/30/11, included a recommendation for a screening colonoscopy every 10 years for individuals ages 50 to 75, with two additional alternatives listed (sigmoidoscopy every five years, with high-sensitivity fecal occult blood testing every three years, or screening with high – sensitivity fecal occult blood testing annually). Colonoscopy was the primary option chosen for colorectal cancer screening in the individuals residing at LBSSLC, and the rate of colonoscopy completion was used in determining compliance, with other options considered if a colonoscopy could not be completed. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 86 names were submitted. Of these, eight individuals had reasons not to order a colonoscopy (e.g., age outside recommended range for screening colonoscopy, refusal of guardian, terminal condition, medically unstable condition, etc.). Therefore, the eligible population was 78 individuals. Of the 78 individuals for whom a colonoscopy or clinical alternative was indicated after the age of 50, 67 had completed an appropriate procedure (86%). From the sample of 18 medical records reviewed, 10 individuals were over the age 50. Of these, eight of 10 (80%) had colonoscopies completed within the past 10 years. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. A total of 43 individuals had a diagnosis of osteopenia and 61 individuals had a diagnosis of osteoporosis. An additional one individual on the list had a normal DEXA scan reading. Of those with osteopenia and osteoporosis, all (100%) had a DEXA scan submitted. There were 14 additional individuals listed for which no DEXA scan results were listed. For some of these, the DEXA scan had been ordered, but not completed. The reason was not provided for including them on the osteoporosis/osteopenia list without a confirmatory T score result. Of the 104 individuals reviewed with osteopenia or osteoporosis, eight (8%) were listed as receiving calcium supplementation, and 15	

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		(14%) were listed as receiving vitamin D supplementation. Of the 61 individuals diagnosed with osteoporosis, 57 (93%) were treated with an additional medication for osteoporosis (a bisphosphonate or Miacalcin). The low rates of calcium and vitamin D supplementation suggested an incomplete database. It appeared this data had not been reviewed, because careful review would have identified the lack of information concerning calcium and vitamin D supplementation. If this data accurately reflected the current status of treatment, it was clearly problematic. The Medical Department should review these datasets at routine intervals, and quarterly reports should be generated providing summary analysis of the findings. Such reports should be distributed to the PCPs, QA/QI Department and Facility Administration. The Dietary Department provided important information concerning calcium and vitamin D requirements, and current consumption in individuals with osteoporosis and osteopenia. For each individual with these diagnoses, the Dietary Department provided a detailed evaluation of the daily requirements of several nutrients, including calcium and vitamin D, as well as the current intake based on prescribed formula feeding rates, or diet, snacks, and percentage consumption. The dietitians were able to calculate whether the intake of calcium and vitamin D was adequate to meet the nutritional needs of the individual. This appeared to be completed for each individual with osteoporosis and osteopenia. When dietary calculations indicated excessive intake of calcium and vitamin D, recommendations were made to the PCP for reduction or discontinuation of supplements. As a result, the Dietary Department provided important information and calculations in guiding the PCP in providing appropriate levels of supplementation of calcium and vitamin D. From the sample of 18 medical records reviewed, 10 had a diagnosis of osteoporosis or osteopenia. Of these, 10 (100%) had a current DEXA scan and T score report available in the active record. Nine (90%) had appropriate medical treatment (one had medications stopped due to comorbid conditions). A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of five individuals were identified with a diagnosis of Down syndrome. All five (100%) had a current thyroid test. <u>Acute and Emergency Care</u> The submitted active record was reviewed for nine individuals who had most recently gone to the Emergency Room. These individuals are listed in the documents reviewed section. These nine individuals had 10 ER visits. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified of the arrival of the individual with appropriate medical background information provided for	

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		five of the 10 ER visits (50%). ▪ Prior to the transfer to the ER, a PCP was on site for one of these transfers. In this one evaluation prior to transfer, the PCP had written an IPN that included the date and time. Vital signs were not recorded. The reason for the transfer was documented. The PCP IPN was in the SOAP format. ▪ Transfer was considered timely in nine of the 10 transfers (90%). For one transfer, the submitted information appeared to be incomplete. ▪ An ER report was submitted from the active records for nine of 10 ER visits (90%). ▪ Reasons for transfer varied. For three ER visits, trauma was the reason documented. Other reasons included: respiratory concerns – two, seizures – one, gastrointestinal concerns – one, urological concerns – one, hypothermia – one, and generalized weakness – one. ▪ It was noted that for nine of the ER transfers, the PCP was not on site for a pre-transfer PCP note to be written. However, in two of these records for which no PCP transfer note was written, the transfer occurred during regular business hours. Seven of these transfers occurred in the late afternoon to early evening hours. It was unclear why notes were not written. Separately, the active record was reviewed for 10 individuals who had most recently gone to the ER and returned. These 10 individuals made 10 ER visits and returns. The list was not identical to the prior review of nine individuals that made 10 ER visits. ▪ When the individual returned to the Facility after evaluation at the ER, nine of the 10 active records (90%) had an IPN. ▪ These IPN post-ER notes included the date, and time in nine of the nine (100%). ▪ Vital signs were recorded in seven of the nine (78%) of the IPN post-ER notes. ▪ A summary of ER information and findings was documented in eight of nine (89%) IPN notes. ▪ The SOAP format was utilized in nine of nine IPN notes (100%). ▪ Three of the 10 records (30%) had additional PCP notes as follow-up to the original concern. The reasons for transfer were as follows: seizures – 2, gastrointestinal concerns – one, trauma – three, urological concerns – one, urinary infections – two, and hyperglycemia – one. ▪ It was noted that a post-ER visit nursing assessment was submitted for five of the 10 (50%) transfers. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review: ▪ All 10 individuals returned to the Facility. None died while in the hospital. Of the 10 individuals that returned to the Facility, eight (80%) had IPNs post hospitalization.	

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		▪ Of the eight post-hospital IPNs submitted, seven (88%) included vital signs. One note was written after communication from the hospital and during transport prior to arrival. Consequently, the individual was not on site for vital sign measurement. ▪ All eight (100%) of the post-hospital IPNs included date and time. ▪ An adequate summary of hospital events and findings was recorded in five of eight IPNs (63%). ▪ All eight (100%) post-hospital IPNs used the SOAP format. ▪ Six records of 10 hospitalized individuals (60%) included a copy of the hospital admission history and physical. ▪ Two of the 10 (20%) included a copy of the hospital discharge summary. ▪ Seven (70%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ Nine of the 10 (90%) included a copy of the hospital discharge instructions. ▪ Two of the 10 (20%) included Hospital Liaison Nurse notes for the individuals. It was not clear if these were not copied, or not filed in the IPN section of the active record for review. Separately, Hospital Liaison Nurse notes were submitted for each of the 10 hospitalizations. ▪ For four of the 10 individuals that returned to the Facility (40%), additional PCP notes were included as part of the follow-up. ▪ Of the 10 hospitalizations, the reasons for the hospitalization included the following: dermatological concern – one, respiratory concerns – three, urological concerns – one, seizures – two, gastrointestinal concerns – three, drug toxicity – one, and fracture – one. Two admissions had more than one significant concern. LBSSLC created a system of accountability for transfer of important information to the ER. Starting 12/1/11, a packet of medical information accompanied the individual being transferred to the ER/hospital setting. The nurse who prepared the packet signed it, as well the person transporting the individual (EMS or Facility staff) and receiving the packet. The Facility responded to the Monitoring Team's document request with a document (i.e., TX-LB-1203-IX.34) entitled: "Length of stay in Infirmary for past six months." The heading of the chart was entitled: "Individuals Temporarily admitted to the Infirmary - 504 E. Mesquite in the past year (Feb 2011- Feb 2012)." Based on this document, during this time, 19 admissions were made to 504 E. Mesquite. More recently, for the prior six months (September 2011 through February 2012), there were six admissions. For the 19 admissions over the 12 months, three were for neurological reasons, three were for respiratory reasons, three were for gastrointestinal concerns, and three were for orthopedic care. For 18 of the 19 admissions over the 12 months, length of stay at 504 E. Mesquite varied from one day to 79 days. For one individual, length of stay was eight	

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		months. From the 18 medical records reviewed, in the prior year, nine (50%) had been hospitalized, required an ER visit, or had outpatient surgery. A member of the Monitoring Team met with the PCPs to discuss any ongoing concerns. One of the unanimous concerns was the lack of triaging, assessment, and information provided for individuals sent to the daily clinic. At times, no indication was included in the IPN section of the record that a problem needed attention, yet the individual was sent to the clinic for evaluation and treatment. This was reflected in the 2/8/12 morning provider meeting minutes, in which a brief notation was made of the need for improved triaging of those who are placed on the clinic list. A recent change had been made in the deployment of nursing duties, and the RN Case Managers were assigned to review those placed on the clinic list to determine if clinical reasons for being seen in clinic were documented. The lack of accurate and complete history and preliminary nursing assessment has the potential to be a significant obstacle in treating acute illness and responding to health status change. The Facility submitted a report entitled: "LbSSLC Infection by Home Report, Report date: 1/1/2011-1/31/12." From this data, the second quarters (December through February) one year apart could be compared for the fiscal years 2011 and 2012. For other quarters, data was not available for comparison between quarters one year apart. For the second quarter of both years, the reported infections totaled similar numbers: 79 in FY 2011, and 86 in FY 2012. The Facility submitted various lists and reports related to the diagnosis of pneumonia. The following summarizes the various lists, as well as the discrepancies identified: ▪ The Facility submitted data per month for different categories of infection. Reports were submitted entitled: "LbSSLC Infection by Month, Home, Person Report," and separately, "LbSSLC Discrepancy Report." These were submitted for the months of August 2011 through January 2012. The two reports were compared and the data for pneumonia was identical in both these reports. This information was presented as a graph. The following indicates the number of pneumonias reported per month: August 2011 - three, September 2011 – two, October 2011 – five, November 2011 - five, December 2011 – three, and January 2012 - four. ▪ Separately, data for pneumonia was submitted in table format entitled: "Absolute number of new cases by month," and pneumonia was one of the diagnoses tracked. The number of pneumonias documented for December 2011, and for January 2012 agreed, but according to the table, the other months indicated fewer cased of pneumonia. The reason for the discrepancy was not	

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		identified. ▪ Separately, a list of individuals newly diagnosed with pneumonia in the past year was submitted. The names and dates of pneumonia agreed with the reports identified in the first bullet. However, several individuals with pneumonia were not identified on this list [i.e., Individual #175, Individual #225, Individual #176 (8/5/11 pneumonia not listed), Individual #72, Individual #196, and Individual #118]. ▪ From a separate document entitled: "List of individuals who have had a diagnosis of pneumonia in the last six months and taking food/liquid by mouth, type of liquid (amount of thickening) and type of texture of solid food ordered, and last swallow study," an additional individual (i.e., Individual #192) was listed as having had pneumonia, but was not included in any other documents listing pneumonias. ▪ Avatar tracking forms were requested for pneumonia, but the Facility indicated "this data is not currently available at this time." This had been a rich source of material for pneumonias, and a source of comparison to other databases. The various databases for pneumonia continued to have discrepancies, and it is recommended that the Facility continue to resolve the discrepancies in the various databases. Additionally, a list submitted indicated that there were seven individuals with tracheotomies. A list of fractures was submitted which occurred from 10/1/11 through 2/6/12. The list included three fractures in three individuals. All were lower extremity fractures. Two of these required hospitalization. Additionally, there were eight other admissions to the ER for injuries of individuals at LBSSLC. None of these eight ER visits required further hospitalizations. Four were open wounds. <u>Chronic Conditions and Specific Diagnostic Categories</u> Chronic constipation had been diagnosed or was treated with medication on at least a weekly basis in 165 of the individuals residing at LBSSLC. According to data submitted, no individuals required admission to the hospital for treatment of bowel obstruction or bowel perforation over the past year. As part of the review of 18 medical records, GERD was reviewed. Of the 18, 12 were diagnosed with GERD. Of these 12, all twelve had medical treatment, two had surgical procedures for treatment of GERD, and eight had diagnostic procedures for GERD in the prior year. That all 12 were prescribed medical treatment, and eight of the 12 (67%) had a diagnostic procedure completed in the prior year indicated an appropriate response to the diagnosis. However, the other six records were not reviewed to determine if there	

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		were signs or symptoms or findings that would indicate the need for further evaluation of GERD. Additionally, since 67% of this sample had GERD, it is recommended that the State Office provide a clinical guideline for GERD, due to the high prevalence and potential variable options in diagnostic evaluation and treatment. Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. No individuals were newly diagnosed with diabetes mellitus type II. Five individuals were newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year. Since the Monitoring Team's last visit, a Skin Integrity Committee met once. Minutes were submitted for a meeting held on 12/7/11 (the prior committee meeting was 8/23/11). In these meeting minutes, there was documentation of one individual at high risk for skin breakdown, but it was unclear the current status of skin integrity. Separately, the morning medical provider meeting continued to track progress of the pressure ulcer, and provided valuable information including dates of wound clinic appointments, changes in dressing orders, and progress reports by the PCP. There was no other mention in the minutes concerning skin breakdowns since the prior meeting in August 2011. It is recommended that the minutes reflect the number of ulcers, including location, and stage of ulcer, and current status, since the last committee meeting. If there were none, then it would be helpful to clearly state that information. Separately, from a database entitled: "Absolute number of new cases by month," which included decubitus as a category, only one decubitus ulcer was listed, and that occurred in September 2011. The committee minutes indicated the focus of the committee was on current treatment options (wound care dressings) that LBSSLC should considered. Additionally, according to the minutes, an in-service training was provided to the committee members via a handout on pressure sores and a pressure ulcer healing chart. This information was not submitted as part of the minutes. A list was submitted indicating that as of 3/19/12, approximately 143 individuals had a diagnosis of a seizure disorder. A total of 42 of these individuals were not currently receiving an antiepileptic medication. It is recommended that the Medical Department review this list to ensure that this information is accurate. A list of the dates of last known seizure and type of seizure in these individuals would provide important historical information. A review of the list also would ensure that the history of a seizure being ruled out did not subsequently become misinterpreted in the documents as a history of seizure disorder. The Facility submitted information concerning antiepileptic medication usage. As of 2/9/12, 101 individuals were prescribed antiepileptic medication. Of these, 43% were	

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		prescribed one antiepileptic medication, 32% were prescribed two antiepileptic medications, 15% were prescribed three antiepileptic medications, 7% were prescribed four antiepileptic medications, and 4% were prescribed five antiepileptic medications. Six individuals were considered to have a refractory seizure disorder. One of these individuals was currently being evaluated for a VNS placement. Five of these had a VNS implant. In the prior six months, seven individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. One individual required four ER visits. Two individuals were considered to have status epilepticus. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 38 (38%) individuals with seizures were prescribed Dilantin, four (4%) were prescribed Primidone, 11 (11%) were prescribed Phenobarbital, and one (1%) was prescribed Felbamate. Additionally, six individuals had a VNS implant (one of these individuals expired during the hospitalization in which a VNS was placed), leaving five individuals with VNS residing at LBSSLC. From September 2011 through January 2012, there were 154 appointments for neurology consultation. The rate of appointment completion was not clear from the information submitted. One individual had been hospitalized for seizures, and was unable to complete the appointment. 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 at least twice over the past six months. ▪ For five individuals (100%), the notes indicated the frequency of the seizures (seizure control). ▪ Five of five (100%) included a review of current medications for seizures and dosages. ▪ Five of five (100%) included recent blood levels of antiepileptic medications. ▪ Five of five (100%) included recommendations. ▪ For one of five individuals (20%), reference was made to the presence or not of side effects at the time of the visit. A list of those with an incident of ingesting an inedible item or liquid in the prior six months was submitted, dated 2/22/12. Twelve individuals were listed. One individual was hospitalized, and required surgical removal of the foreign body. Of the 12 individuals, only six (50%) had a DSM diagnosis of pica, and only six (50%) had pica listed on the active problem list. As pica often is considered life long or until significant decline in functional status (from a stroke, etc.) condition, it is recommended that the	

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		lack of documentation of pica on the active problem list be resolved/corrected/updated. Separately, the drug regimen review profile was submitted for three individuals with a J-tube. Other information was not available at the time of the review of the drug regimen review profiles for these three individuals. However, there appeared to be some irregularities in the drug regimen review profile that both the PCPs and the Pharmacy Department should have identified and clarified before the order was completed. For example: ▪ Individual #6 had a J-tube, but one of the orders had a route of G-tube. It is not known if he had both a J- and G-tube, but as the other medications were given through a J-tube, and the notes of the drug regimen review profile indicated that medication was given through the J-tube, the order (or the note) might need further clarification. ▪ Individual #176 has a J-tube, and he had an order for Sucralfate. As Sucralfate acts by coating the gastric lining, administration through a J-tube appeared to make the medication ineffective. ▪ Individual #225 had a J-tube and was prescribed Zegerid, which contains an antacid. As the diagnosis provided was GERD, the impact of the antacid component of Zegerid should have led to a critical review of the role of antacids through J-Tubes. The Omeprazole component appeared appropriate. The notes section at the top of the drug regimen review profile indicated that medications were to be given by G-tube, but the medication orders for route indicated J-tube (except those given topically or nasally). The orders/notes appeared to need reviewing and updating to provide clarity as to the route of administration. Although no accompanying information was provided to determine the rationale for these medications and their administration through a J-tube, if documented, both the ordering of these medications via J-tubes and the subsequent screening process when the new order occurred, as well as the ongoing QDRR review did not address this issue. The PCPs might need further in-service education concerning the topic of medications and J tubes. The pharmacy software program might not address the issue of appropriate route, because these would not be part of drug-drug interactions, allergies, or side effects. It is recommended that the pharmacy research this area of concern. If these medications were appropriately administered, and the route was correct, then the WORx notes section should reflect this information. If there were reasons to give the above-mentioned medications through a J-tube, then the PCP IPN and pharmacy needed to ensure it was documented in the record, both in the patient intervention section and in QDRRs when these medications were used chronically. <u>Do Not Resuscitate Orders</u> Based on a list the Facility provided, dated 6/16/11, a total of 10 individuals at the	

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		Facility had DNR orders in place, categorized as Resuscitative Status II. Updated information since that time was not provided. The definitions of the categories of DNR status were submitted. Resuscitative Status I was a full code, and all life saving measures were indicated. Resuscitative Status II was defined as: "conservative therapeutic and supportive measures will be performed to reduce mortality and morbidity, excluding initiation of endotracheal intubation and external cardiac massage." Additional instructions to meet the unique needs of the individual were also considered. Resuscitative Status III was defined as: "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." Additional instructions to meet the unique needs of the individual were also considered. Of these 10 DNR orders, the date of implementation of the DNR orders ranged from 2005 to 2011. One individual was receiving hospice services. For all 10 (100%), adequate clinical justification was provided for the DNR. Two had end stage renal disease, two had a diagnosis of cancer, two had Alzheimer's dementia, and four had severe pulmonary disease (restrictive lung disease, or chronic respiratory failure). It is recommended that the Medical Department make an updated list available to the clinical departments on an ongoing basis, because knowledge of DNR status is important in providing onsite treatment and when an individual is transported for ER treatment. The Resuscitative Status II forms, according to State policy, needed to be updated yearly for continuation of the DNR status. Of the 10 names on the DNR list, current Resuscitative Status II forms were submitted for nine (90%). Six of the 10 had additional PCP IPN notes confirming the continuation of the DNR status. For one individual on the list, Individual #14, this information was not submitted. On 3/1/12, one additional individual had a DNR status determined, and had a completed Resuscitative Status II form submitted, which brought the updated total of individuals with Resuscitative status II to 11. The Facility appeared to review the DNR status yearly to determine whether the DNR status remained applicable. During the Monitoring Team's visit, for one individual approaching terminal status, there was discussion at each of the morning provider meetings. Background information and daily updates were provided to the attendees. There appeared to be a lack of structure in ensuring essential aspects of decision-making were completed for those for whom a DNR status was being considered and/or implemented. For example, no structure was in place related to the decision process for ensuring a diagnosis was identified to confirm a terminal status, or what physiologic parameters would reflect a terminal condition. When asked, the community physician was able to provide detailed documentation of the terminal diagnosis, and several pathophysiologic indicators confirming this diagnosis. Also important, articulation in writing was available to show that the medical team had	

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		paid attention to the individual's pain and comfort management. There was no identified involvement of the ethics committee in this case, which might have provided guidance to the IDT, the morning provider meeting, and to the family. Interface between the family and the ethics committee might have helped to ensure that all concerns were addressed and questions answered, and that all members of the IDT understood and agreed to the end-of-life decisions. The Facility submitted information indicating there had been no ethics committee meetings since the Monitoring Team's last visit. The above case indicated the need for a structured approach to thorough discussion and documentation of this important area of decision-making. The use of a simple checklist would help to ensure the essential components of the decision-making process are completed. By including the date of completion and attaching a copy of the documentation to the checklist, a record could be maintained to show that essential steps had been completed. Mock Code Drills and Emergency Response Systems Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement. Transitions to the Community The Post-Move Monitor submitted information indicating that five individuals had transitioned to the community in the prior year. Three of these had transitioned in the prior six months. As of 2/17/12, no reportable events had occurred, such as hospitalizations, ER visits, or 911 calls. However, as discussed onsite, the Community Living Discharge Plans did not adequately address individuals medical needs, and, as noted above, annual medical assessments did not adequately define the medical supports and services an individual would need to safely and successfully transition to the community. This is an area in which the Medical Department needed to make significant changes.	
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.	Non-facility Physician Case Reviews The Facility submitted information from an external medical audit from August 2011. The QA Department created and tracked a total of 69 action plans, of which 100% were tracked to closure. During this audit, identified as Round 2, essential components needing improvement (scored as number of "no" answers to the audit questions) were identified by the numbers listed on the audit tool. These included: "2. Is the active problem list dated and signed when it was last reviewed?" "3. Is there evidence that the active problem list was updated with each new problem or as problems were resolved?" "4. Is the annual physical exam and summary current?" and "5. Is the annual physical exam complete	Noncompliance

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		including PMH (past medical history), family hx and a plan of care?" Nonessential components needing improvement included: "9. Have the appropriate immunizations been given?" "14. Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the Quarterly Drug Regimen Review Form within 15 business days?" "16. Do the medication orders for acute conditions include indication and duration for all medications prescribed?" "23. Is the provider's documentation organized in appropriate SOAP format (including assessment and plan)?" and "26. When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" During the prior six months, the Facility completed two non-facility physician case reviews. The following represents a synopsis of the information: For the November 2011 external peer review audit, ▪ PCP compliance in essential areas ranged from 68% to 90%. As the Facility had determined compliance to be 100%, no PCP was compliant. ▪ For areas considered non-essential, compliance ranged from 63% to 89%. As the Facility had determined compliance to be 80%, one PCP was compliant. ▪ Audits were completed on all four PCPs' caseloads. ▪ Areas that appeared to need improvement included the following questions/probes for essential areas: "3. Is there evidence that the active problem list was updated with each new problem or as problems were resolved?" "4. Is the annual physical exam and summary current?" "5. Is the annual physical exam complete including PMH, family hx, and a plan of care?" and "17. Are the diagnostic tests and/or therapeutic procedures medically appropriate?" ▪ These areas of concern (#3, #4, #5) also were identified in August 2011, and further progress was needed in these areas. ▪ Areas that appeared to need improvement included the following questions/probes for non-essential areas: "8. Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products. If the individual uses tobacco products was there documentation for cessation of tobacco use?" "16. Do the medication orders for acute conditions include indication and duration for all medications prescribed?" "21. Is each of this person's progress notes and orders signed, dated, and timed?" "22. Is the provider's documentation legible?" "23. Is the provider's documentation organized in appropriate SOAP format (including assessment and plan)?" and "26. When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" ▪ Areas of concern that were identified in August 2011 and were of continuing	

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		concern included #16, #23, and #26. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. The QA nurse/QA Department identified 88 total action plans. All 88 (100%) were reviewed by QA. Action plans that were completed totaled 75 (85%). Thirteen actions plans remained to be completed. The date of this QA information was not submitted. The QA Department should include dates for each report generated by their department. There was a QA follow-up document entitled "audits for round 3," dated 2/10/12, but it was not clear if the information tabulated in the section on total action plan completion was more recent information or from an earlier date, or whether the date represented when the table of information was submitted. For the February 2012 external peer review audit: ▪ PCP compliance in essential areas ranged from 67% to 80%. As the Facility had determined compliance to be 100%, no PCP was compliant. ▪ For areas considered non-essential, compliance ranged from 77% to 94%. As the Facility had determined compliance to be 80%, two of three PCPs were compliant. ▪ Audits were completed for three of four PCPs' caseloads. ▪ Areas that appeared to need improvement included (for essential areas these were submitted per PCP rather than a total): "#3. Is there evidence that the active problem list was updated with each new problem or as problems were resolved?" "#4. Is the annual physical exam and summary current?" "#5. Is the annual physical summary complete including PMH, family hx, and a plan of care?" "7. Are drug and/or food allergies, intolerances or adverse drug reactions appropriately documented?" ▪ These areas of concern (#3, #4, #5) also were identified in the November 2011 audit, and further progress was needed in these areas. ▪ Areas that appeared to need improvement for non-essential areas included: "8. Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products. If the individual uses tobacco products was there documentation for cessation of tobacco use?" "16. Do the medication orders for acute conditions include indication and duration for all medications prescribed?" "21. Is each of this person's progress notes and orders signed, dated, and timed?" and "26. When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant?" ▪ These areas of concern (#16, #21, #26) also were identified in the November 2011 audit, and further progress was needed in these areas. ▪ For the medical management external audit, range of compliance for PCPs was	

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		88 to 89%. For one PCP audited, no information was included concerning compliance. For one PCP, the caseload was not audited or the information was not submitted. ▪ The three areas of medical management reviewed were diabetes, osteoporosis, and pneumonia. Each area had a set of questions focused on the clinical topic. The State Office developed these questions, which focused on clinical review of quality medical care. Compliance was 100% for diabetes for the three PCPs reviewed. Compliance was approximately 70% for osteoporosis, and 90% for pneumonia. ▪ Areas that appeared to need improvement for medical management included: "3. Is there a diagnosis of a pathological fracture?" and "10. Did the provider order respiratory therapy?" ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. The QA nurse/QA Department identified 49 total action plans from the external audit for the three PCPs reviewed. For the medical management audit, there were eight action plans identified for two PCPs. No action plan totals were submitted for one PCP that was audited. No follow-up information was available, because the most recent external audit occurred approximately one month prior to the Monitoring Team's visit. Separately, copies of the February 2012 external and internal audits were submitted for review. The total numbers of questions/concerns did not match the number of corrective action plans in the information discussed above for the February 2012 external audit. Presumably, this was because the external and internal audit information was submitted together rather than separately. Three of four PCPs were audited, according to the information submitted, which was consistent with the previously discussed information submitted separately. For one PCP, four individuals were reviewed, and 44 questions or concerns were generated from the external audit or the internal audit, which occurred at the same time. It was noted that some of the 44 questions were duplicated findings in both the internal and external audit. For instance, 44 questions or concerns from the external and internal audits were listed, but 10 concerns were determined by both audits (which represented a total of 20 questions or concerns). Subtracting the duplicate concerns, this PCP had 34 questions or concerns. Another PCP had eight individuals reviewed, with 25 questions or concerns listed. Subtracting the duplicate listing of concerns, there were 20 questions or concerns. For the third PCP, six individuals and 48 concerns/questions were listed. Subtracting the duplicate listings, there were 36 concerns/questions. The duplication indicated some level of agreement between external and internal audits. However, there was no information provided concerning computation of inter-rater reliability.	

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		All the PCPs participated in the internal audit process. No information was submitted concerning the varied number of individuals reviewed per PCP, because the caseloads for these three PCPs were similar. The reason also was not provided for the lack of audit information for the fourth PCP. This information from the Medical Department was the raw data from these audits, as opposed to a report summarizing the findings. Both administrative documentation and clinical management audits were completed. Because the Medical Compliance Nurse participated in completing monitoring and review of the data, this information was incomplete due to the fact that this staff member was on an extended leave. Additionally, as mentioned in the prior discussion concerning the February external audit, since the data was new, no action plan follow-up information was available from the QA Department. The non-facility medical provider provided a summary exit review of the findings for the 2/21/12 to 2/22/12 audit. One medical provider was listed as completing the review, although the raw data indicated two medical providers completed the audit process. Areas needing improvement included: documenting allergies on physician's orders, updating the active problem list, and providing more medical history on the consult referrals. A noted strength was the quality of the annual physical examination and medical summary. It is recommended that the Facility track summary information for each PCP over time, including totals of corrective action plans. An analysis to determine if areas of concern are resolved over time would be important to identify any trend of improvement in that area. Trending over serial external and internal audits would help the Medical Department to determine where progress has been made and challenges remain. Keeping internal and external audit information separate would be helpful in fulfilling the requirements of the Settlement Agreement, because the information for the external audits is helpful in providing evidence for Section L.2 and the internal audit is helpful in providing evidence for Section L.3. More importantly, it is important to identify differences in the external and internal audits to assist in determining if differences exist in the interpretation of questions on the tool, or the standards being applied. Inter-rater reliability information should be calculated and available as the internal and external audits are conducted together. For each of the internal and external audits, Medical Department initiatives should be implemented to resolve and prevent deficiencies. Quarterly reports, including audit results and trend analysis, as well as summaries of	

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		progress in Medical Department initiatives would provide the Facility with a method for tracking its progress and deciding on next steps, as well as provide documentation of progress consistent with the goals of the Settlement Agreement. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews. Five deaths were reported from 9/10/11 through 2/22/11. The clinical information was reviewed for these: ▪ The average age was 61 (varied from 49 to 77). ▪ The causes of death were: cancer of the prostate – one, sepsis - three, cardiac condition with complication of aspiration pneumonia - one. ▪ An autopsy was performed in four of the five (the results were pending for one death). ▪ DNR status was ordered while residing at LBSSLC for one of the five, and ordered for four while in the hospital. ▪ Four died in a hospital setting. ▪ Four had multiple or prolonged hospitalizations prior to death. ▪ Four had G-tube or J-tube placement. ▪ Four were aggressively treated with prolonged hospitalizations prior to death. All five had hospitalizations in the year prior to death. One was on hospice services prior to death. ▪ There were concerns of lack of nursing documentation of vital signs identified in two of the nursing services QA death reviews. However, this was not clearly defined/determined as a concern needing formal action steps and closure by the clinical or administrative death review committees. The administrative death review recommendations related to nursing appeared to be vague and no measurement goals were provided. There was no follow-up information concerning this gap in nursing care ▪ There also was concern of lack of timely nursing assessment of health status change identified in two of the QA reviews of nursing services. However, this was not clearly defined/determined as a concern needing formal action steps and closure by the clinical or administrative death review committees. As noted above, the administrative death review recommendations related to nursing appeared to be vague without measurement goals. There was no follow-up information concerning this gap in nursing care ▪ For two of the reviews, there were no quarterly medical reviews. This was identified by one or more death review committees and was consistent with the Monitor Team's findings during record reviews. Since the Monitoring Team's last visit, five clinical death review investigations were completed. Of these, two had follow-up recommendations. The clinical death reviews	

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		included from zero to two recommendations, for a total of three recommendations. Information was requested for follow-up on these recommendations. There was no information submitted to address these specific recommendations. The administrative death review committee also made six recommendations based on four reviews. Information was not submitted for follow-up of these areas. The nursing QI review also had several recommendations, and the status of these was discussed with the QA Department. There appeared to be no clear route for further tracking these recommendations. If the recommendations did not formally become part of the administrative death review recommendations, no process appeared to exist to document the next steps for these nursing recommendations. It is recommended that this process be formalized, that any recommendations not agreed upon by the Nursing Department or Facility Administration be stated clearly with reasons documented. If the recommendations are agreed upon, then there should be documented tracking until closure.	
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>Medical Department Internal Reviews</u> As part of the quality review of medical care and health care, in-service training was provided to the PCPs concerning implementation of the new medical policies. Specific content questions of the medical peer review audit were discussed, on the following dates of in-service training: ▪ "Legibility of documentation: Question #22 on the Medical Provider Audit," on 11/14/11 through 12/5/11; ▪ "Consults and IPNs, within five business days. Question #27 on the Medical Provider Audit," on 11/14/11 through 11/28/11; ▪ "Medical Provider Audit Question #24: Pertinent negative and positive findings in acute conditions: all acute conditions require an IPN that contains positive and negative findings," on 10/24/11 through 12/5/11; ▪ "Addressing Question #23 on the Medical Provider Audit regarding SOAP notes," on 10/24/11 through 11/17/11; ▪ "Necessary components of the physical, future summaries must include this pertinent information," on 10/3/11; and ▪ "Use of preventive care flow sheets in the active record(s)," on 10/24/11 through 11/17/11. Data concerning internal medical peer review was included in the discussion with the external medical peer review in relation to Section L.2. <u>Medical Department Initiatives and Improvement Projects</u> The Medical Compliance Nurse, and the Medical Director in the absence of the Medical Compliance Nurse, tracked the ER visits and the hospitalizations on a quarterly basis. The trending of this information indicated that there was an increase in the dislodgement	Noncompliance

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		of G-tubes. It was determined that further guidance and instruction was needed for nursing/direct support professionals to prevent dislodged tubes, including use of abdominal support binders as a physical barrier to prevent "catching" the tube on clothes and equipment. In part, this was identified through review of this quarterly data, and was an example of how the information was directly used to assist in care of the individual. The Facility's follow-up on this information had reduced and/or eliminated visits to the ER for dislodged feeding tubes. This information was tracked through the morning provider meeting minutes of 1/4/12. Data, which had been tracked quarterly, indicated that 26.5% of the ER visits in the third quarter were for dislodgment of feeding tubes. Corrective action was outlined. The CNE was to order different size abdominal binders, and implement training of the direct support professionals on care of the feeding tube. Attention was to be paid to positioning, and marking the feeding tubes with a permanent marker as they exited the ostomy sites. This would then be used as a reference to indicate any migration outward of the tube. The dates of some of the action steps were submitted as part of a sample of the morning provider meeting minutes. For instance, according to the closure minutes, on 1/17/12, the action steps of ordering different size abdominal binders, marking enteral feeding tubes, and recording this on the treatment sheets were completed. From 3/5/12 through 3/19/12, nurses were in-serviced concerning "gastrostomy stoma care." The Medical Director indicated that in the following months, individuals were not sent to the ER for dislodged feeding tubes, and that the steps taken to reduce and eliminate this concern had accomplished their goal. Additionally, another concern identified was teaching the nursing staff to replace suprapubic catheters. In the past, if they fell out or were clogged, individuals had been sent to the ER for replacement. This additional training allowed the individual to stay in the residence. This issue also was identified through the quarterly data. Similarly, one individual was identified as responsible for serial ER visits for hypothermia. Subsequent discussion at the morning meetings led to a medical reason for the hypothermia and treatment of the hypothermia. An additional initiative was created based on a review of the quarterly data for hospitalizations. It was noted that the number of individuals hospitalized for pneumonia increased in the third quarter (note: this is different from the finding of a total decrease in hospitalizations from the second to third quarters, as discussed later in this section). Pneumonia was found to be responsible for 30% of the hospitalizations in the third quarter, and the percentage had actually increased from the prior quarter. Corrective actions required an interdisciplinary approach to this challenging topic, including the following: all individuals with pneumonia were to be reviewed to ensure a GERD work-up had been completed; an oral care program, including suction tooth brushing, was to be implemented in the weeks following (a 1/10/12 conference focused on suction tooth	

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		brushing); the CNE and the Unit 1 Manager were to discuss training of direct support professionals caring for individuals with enteral feeding tubes, and the importance of positioning for prescribed times during and after feeding; training of nurses on chest physiotherapy; and training the Respiratory Therapists on proper positioning during chest physiotherapy. This discussion was also documented as part of the morning provider meeting of 1/4/12. This was another positive example of use of data to identify areas needing improvement, and development and implementation of a reasonable action plan. For the third and fourth calendar quarters, each showed a decline in the number of ER visits from the prior quarter. The third quarter ER visits totaled 34, and the fourth quarter ER visits totaled 27. This demonstrated analysis and clinical implementation of the steps to address the findings to improve care at LBSSLC. However, as noted later in this section, different datasets appeared to exist at the Facility with different statistics. It is recommended that the Medical Department review database management to ensure accurate and complete data is available for analysis, and that the Medical Department data is consistent with the Facility data. The data for hospitalizations indicated a decrease in the number of hospitalizations from the second to the third quarter by 17%. There was an upswing in hospitalization rates during the fourth quarter. This appeared to be related to respiratory illness (diagnosed as pneumonias, but not aspiration pneumonia), which had seen a general increase in the community and at the regional hospitals. It was noted that despite immunization, one individual developed influenza infection. Several staff also had developed influenza infection. It was noted that the immunization rate of employees was less than optimal (i.e., the Medical Director estimated 40% of staff were vaccinated). As of 3/21/12, 361 employees had been vaccinated for influenza, but the denominator of the employee census was not provided, and the percentage receiving the flu vaccine could not be calculated. An immunized staff population would assist in preventing the spread of influenza to and across LBSSLC. It is recommended that current promotion of vaccination to the staff be reviewed for additional approaches, especially in reducing the potential barriers to receiving the vaccination while on duty. Separately, the Facility submitted a list of individuals who were treated in the ER from 2/1/11 through 1/31/12. From this, information for the number of ER visits per month was obtained for the more recent months of September 2011 through January 2012: September 2011 - 14 ER visits, October 2011 - seven ER visits, November 2011 - nine ER visits, December 2011 – six ER visits, January 2012 - 10 ER visits. Additionally, for July 2011, there were nine ER visits and for August there were 11 ER visits. The prior Medical Department analysis indicated that for the third calendar quarter (July to September 2011), there were 34 ER visits, and in the fourth calendar quarter (October to	

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		December 2011), there were 27 ER visits, but the information recorded with this dataset indicated that there were 22 ER visits in the fourth quarter. The Medical Department might have more complete data than the Facility information provided in this separate dataset. Similarly, the Facility submitted a list of individuals who were hospitalized from 2/1/11 through 1/31/12. From this list, information was obtained for the more recent months of September 2011 through January 2012 for the number of hospitalizations: September 2011 - six hospitalizations, October 2011 - nine hospitalizations, November 2011 – nine hospitalizations, December 2011 - nine hospitalizations, and January 2012 - nine hospitalizations. Additionally, for July 2011, there were seven hospitalizations and in August 2011, there were four hospitalizations. Calculating from this calendar quarter information, the third quarter had 17 hospitalizations and the fourth quarter had 27 hospitalizations, an increase of 10 (10/17 = 59%). Separately, the Medical Department noted 20 hospitalizations in the third quarter, and 28 in the fourth quarter. This was a 40% increase from the prior quarter (8/20=40%). The Medical Department and the Facility's overall data indicated some discrepancies, and a review of the source of the information should be conducted to identify the reason for the discrepancies. The Medical Department is unable to plan without accurate information and an accurate baseline from which to determine future progress. Additionally, the internal audits indicated a recurrence of the same concerns without improvement. Focused efforts should be identified and implemented to address the essential components requiring 100% compliance. The Medical Department should review this lack of progress and create and implement action plans, including monitoring to determine progress in these areas. Further the internal audits, as mentioned previously, should expand beyond the every six-month review. Depending on identified needs, the Medical Department should be able to begin to generate monthly information and quarterly trend reports for a variety of health care areas, such as mammogram completion, colonoscopy completion, ER visit data, post-hospital PCP IPN notes, morning provider meeting recommendations that are referred to the IDT for ISPA consideration, etc. Many of the components discussed in Section L.1 should have a medical QI component developed and implemented, with quarterly reports. This would allow the Medical Department to identify and correct areas of need in their earliest stages.	
L4	Commencing within six months of the Effective Date hereof and with	The Medical Department submitted several clinical guidelines adapted from the State Office clinical guidelines. These clinical guidelines were adapted to the needs of the	Noncompliance

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	full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Facility and implemented. These included: ▪ LBSSLC - Health Services: Clinical guidelines – enteral feedings, dated 1/13/12; ▪ LBSSLC – Health Services: Clinical guidelines - UTI, dated 2/3/12; ▪ LBSSLC - Health Services: Clinical guidelines – constipation, dated 1/13/12; ▪ LBSSLC – Health Services: Clinical guidelines – aspiration pneumonia, dated 1/13/12; ▪ LBSSLC – Health Services: Clinical guidelines – osteoporosis, dated 1/13/12; ▪ LBSSLC – Health Services: Clinical guidelines - seizures, dated 1/13/12; and ▪ LBSSLC – Health Services: Clinical guidelines – diabetes, dated 1/13/12. As mentioned in Section H, these guidelines provided practical guidance to PCPs, nurses, and direct support professionals in caring for the individuals for which these clinical concerns apply. The guidelines also defined specific clinical indicators, either directly or which could be extracted from the documents and amended for use. As these were recently implemented at LBSSLC, and as the Medical Compliance Nurse remained on leave at the time of the Monitoring Team's visit, the Medical Department had not utilized these guidelines to develop clinical indicators for data collection. The morning provider meeting of 2/9/12 recorded that there was an in-service provided to the PCP s concerning these guidelines. There was no discussion recorded regarding the implementation process or the interface with nursing and residential services, although these departments also had a role in successful application of the clinical guidelines. No information was provided concerning when the Nursing and Residential departments would be in-serviced on these guidelines, and/or the specific steps the staff in these departments would take with individuals for whom the clinical guidelines were applicable. As noted above, there was no documentation of discussion concerning which clinical indicators would be chosen to measure compliance with these clinical guidelines. As the clinical guidelines were newly implemented at the time of the Monitoring Team's visit, there was no information or evidence that the contents of the guidelines were being reflected in the practice patterns of the PCPs. In part, this will be reflected through serial external peer reviews, but trends could be determined at an earlier stage through the internal peer review process. The external peer review provided a baseline for three of the diagnoses for which there were clinical guidelines. There was 100% compliance for one of the diagnoses reviewed. It is suggested that additional clinical indicators be measured to assure the breadth of diabetes management is reviewed. It is likely that the extensive diabetes clinical guideline, when implemented, would have measurable positive impact on the health of the individuals, but the audit questions might have been too general or there might not have been standardized guidance in what to measure.	

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		There was no inter-rater reliability data concerning the area of medical management.	

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

1. The Facility should ensure all clinical personnel maintain current CPR certification, and that this is documented. (Section L.1)
2. The Facility's information system should include the CME topics completed per date for each PCP, to ensure each course or topic is counted only once. In addition, the Facility's tracking system for CMEs should include the topics covered at the conferences. It is understood that for continuing medical licensure in Texas, there are CME requirements that the Texas Medical Board tracks. However, in addition to the requirements for Texas medical licensure, the Medical Department should ensure at intervals that the CME hours accumulated are applicable to the breadth of primary care clinical practice required for the provision of quality medical care at LBSSLC. Tracking CME to ensure it includes primary care topics would assist in providing additional evidence that the medical staff are knowledgeable and are current in medical care practices applicable to the individuals residing at LBSSLC. (Section L.1)
3. With regard to the morning provider meeting, if there was daily rather than periodic four-week discussion of items that had been closed and discussion of items not closed, then further clarity should be provided in a written policy/procedure/protocol, including expectations regarding the morning provider meeting minutes. (Section L.1)
4. Data should be collected to reflect the activity of the morning provider meeting, such as the number of closure concerns identified per month, the number of closure concerns resolved with documentation per month, the number of closure concerns outstanding/unresolved per month, the number of recommendations made to the IDTs, and the number of ISPAs created to address the recommendations or concerns identified during the morning provider meeting. Such data should be analyzed to determine if issues identified are being closed in a timely manner, and that IDTs are responding appropriately to recommendations made during the morning provider meeting. (Section L.1)
5. The Facility should ensure the completion and the timely filing of annual medical assessments. (Section L.1)
6. The Medical Department should review and define the essential components that should be included in the section of the annual medical assessment that addresses the individual's potential to transition to a community setting. Generalizations should be replaced with specific steps that can be planned and implemented as part of a transition plan. (Section L.1)
7. The PCPs should provide guidance for the most significant diagnoses for entry onto the DG-1 form. (Section L.1)
8. The Medical Department should review and implement actions to address the missed appointments for offsite consultations, with the goal to reduce the numbers of individuals missing appointments, as well as the rate of missed appointments. (Section L.1)
9. The Medical Department should track missed appointments for onsite specialty clinics, including the reasons for the missed appointments. Such data should be analyzed, and actions taken on an individual and systemic basis, as appropriate. (Section L.1)
10. For those with behavioral issues that impede their ability to attend appointments, IDTs should meet, and meeting minutes should document the teams' decisions related to amending the ISP or the BSP, if applicable.
11. A system should be put in place, possibly involving the QA Department, to monitor missed appointments, including the quality of the team discussion, decisions, and corrective action plans. (Section L.1)
12. The Medical Department should ensure appropriate documentation is maintained in the active record before and during administration of pre-visit sedation. (Section L.1)
13. The Medical Department should review the osteopenia/osteoporosis, mammogram, and colonoscopy datasets at routine intervals, and quarterly reports should be generated providing summary analysis of the findings. Such reports should be distributed to the PCPs, QA/QI Department and Facility Administration. (Section L.1)
14. The Facility should resolve the discrepancies in the various databases. (Section L.1 and Section L.3)
15. In reference to the Skin Integrity Committee minutes, the minutes should reflect the number of ulcers, including location, and stage of ulcer, and

current status, since the last committee meeting. If there were none, then it would be helpful to clearly state that information. (Section L.1)

16. For the list of those individuals with a diagnosis of a seizure disorder not currently prescribed medications, the Medical Department should review this list to ensure accuracy. A list of the dates of last known seizure and type of seizure in these individuals would provide important historical information. A review would also ensure that the history of a seizure being ruled out did not subsequently become misinterpreted in the documentation as a history of seizure disorder. (Section L.1)
17. 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)
18. The lack of documentation of pica on the active problem list should be resolved/corrected/updated. (Section L.1)
19. On an ongoing basis, the Medical Department should provide an updated list of individuals with DNR Orders to the residential and clinical departments available. (Section L.1)
20. For those individuals with a terminal condition, the Facility should utilize a structure approach to discussing and documenting this important are of decision-making. The use of a simple checklist would help to ensure the essential components of the decision-making process are completed. By including the date of completion and attaching a copy of the documentation to the checklist, a record could be maintained to show that essential steps had been completed. (Section L.1)
21. The Facility should track summary information for each PCP over time, including totals of corrective action plans. An analysis to determine if areas of concern are resolved over time would be important to identify any trend of improvement in that area. (Section L.2)
22. Keeping internal and external audit information separate would be helpful in fulfilling the requirements of the Settlement Agreement, because the information for the external audits is helpful in providing evidence for Section L.2 and the internal audit is helpful in providing evidence for Section L.3. More importantly, it is important to identify differences in the external and internal audits to assist in determining if differences exist in the interpretation of questions on the tool, or the standards being applied. (Section L.2)
23. Inter-rater reliability information should be calculated and available as the internal and external audits are conducted together. (Section L.2)
24. For each of the internal and external audits, Medical Department initiatives should be implemented to resolve and prevent deficiencies. (Section L.2)
25. Quarterly reports, including audit results and trend analysis, as well as summaries of progress in Medical Department initiatives would provide the Facility with a method for tracking its progress and deciding on next steps, as well as provide documentation of progress consistent with the goals of the Settlement Agreement. (Section L.2)
26. Recommendations from the Nursing QI death reviews should be formally tracked, and any recommendations not agreed upon by the Nursing Department or Facility Administration should be stated clearly with reasons documented. If the recommendations are agreed upon, there should be documented tracking until closure. (Section L.2)
27. 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)
28. The current promotion of vaccination to the staff should be reviewed and additional approaches identified, especially in reducing the potential barriers to receiving the vaccination while on duty. (Section L.3)
29. Clinical indicators should 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: o **Review of Following Documents**: o LBSSLC's Self-Assessment; o LBSSLC's Provision Action Information; o LBSSLC At-Risk Individuals list; o LBSSLC training rosters; o LBSSLC's Nursing Department Presentation Book; o LBSSLC's Monitoring Tools for Nursing; o LBSSLC's nursing staffing data; o LBSSLC's Infection Control Monitoring Tool data; o LBSSLC's Action Plans for Nursing; o LBSSLC's lists of individuals who were seen in the emergency room, and hospital; o Infection Control Summary Reports; o Medical records for the following individuals: Individual #89, Individual #161, Individual #56, Individual #226, Individual #281, Individual #211, Individual #176, Individual #9, Individual #242, Individual #263, Individual #162, Individual #233, Individual #309, Individual #23, Individual #237, Individual #250, Individual #103, Individual #184, Individual #136, Individual #176, Individual #312, Individual #199, Individual #324, Individual #53, Individual #201, Individual #77, Individual #161, Individual #225, Individual #6, Individual #196, Individual #75, Individual #263, Individual #209, Individual #56, Individual #78, Individual #226, Individual #258, Individual #21, Individual #62, Individual #173, Individual #166, Individual #48, Individual #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, and Individual #276; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Real Time Audit tool form and data for Infection Control; o The Facility's immunization database data; o Medical Emergency Response Drills Weekly Reports; o Emergency equipment training schedule for nurses; o Risk Management monthly checks of the Emergency Equipment; o Emergency Response Drills monitoring data summary from Risk Management; o LBSSLC Outbreak timeline documentation; o Infection Control Committee meeting minutes, dated 10/6/11, 12/15/11, 1/10/12; o Infection Control data reports by month, home, and person;

	○ Monthly Residential Rounding data; ○ Standard Precaution Monitoring Tool raw data; ○ LBSSLC Discrepancy Report Totals from October 2011 through February 2012; ○ LBSSLC's Immunization Data; ○ Drug Utilization Discrepancy Reports; ○ Nurse Educator Medication Observation form for onsite medication observation; ○ Completed Medication Variance forms for the review period; ○ Medication Variance data, and graphs; ○ Unexplained Returned Medication Doses data; ○ Medication Safety and Systems Committee meeting minutes, dated 10/26/11, 11/16/11, 12/21/11, 1/25/12, 2/15/12, and 3/19/12; ○ Review of Residential Medication Pass Observations Meeting minutes, dated 2/6/12, and 3/8/12; ○ Emails from Pharmacy to Nursing; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 10/5/11, and 12/14/11; ○ Medication Administration Observation raw audit data; ○ Review of Residential Medication Pass Observations meeting minutes, dated 2/6/12, and 3/8/12; ○ Plan to Reduce Unsigned Medications on Medication Administration Records; ○ Updated Return Medications Pilot: Separation of Medications Into Two Trays; ○ Medication Safety and Systems Leadership Work Session, dated 11/3/11; ○ Medication Error Root Cause Workgroup Meeting minutes, dated 11/7/11; ○ LBSSLC Residential Coordinator Med Pass Monitoring Tool and raw data; ○ Training Program Outline for Medication Pass for Direct Support Professionals; ○ LBSSLC staff follow-up monitoring form for Medication Administration Record blanks and data; ○ Nursing monitoring data for enteral nutrition; ○ Residential Coordinator Medication Pass monitoring forms and data; ○ QA and Nursing meeting minutes, dated 1/20/12, and 2/16/12; and ○ Incident Management Review Team meetings from October 2011 through February 2012. ▪ **Interviews with**: ○ Don Minnis, RN, BSN, Chief Nurse Executive; ○ Jeremy Ellis, RN, Quality Enhancement (QE) Nurse; ○ Eddie McFadden, RN, QE Nurse; ○ Michelle McElroy, RN, Infection Control (IC); ○ Sally Schultz, Ph.D., State Consultant; ○ John Todd, R.Ph., Clinical Pharmacist; ○ Mary Ortiz, Competency Training Department (CTD); and ○ Robin Seale, Assistant Director of Programs. ▪ **Observations of**: ○ Medication Administration at 504 E. Mesquite; ○ Infection Control Committee meeting, on 3/22/12;

	o Pharmacy and Therapeutics Committee meeting, on 3/20/12; and o Use of emergency equipment at Quail, Sparrow, and Fir Residences.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, 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, the Facility's Self-Assessment contained data that were difficult or impossible to interpret, specifically the findings from auditing data on which the Facility had based its findings. As noted in previous reports regarding the Facility's monitoring process, a number of problematic issues including the lack of clear and specific instructions for the Health Monitoring Tools for Nursing, no validation of the clinical competence of the auditors scoring the Health Monitoring tools, the lack of a procedure for establishing inter-rater reliability for each of the Nursing Health Monitoring tools, and no standardization regarding the presentation of the monitoring results, rendered the reliability of the Facility's data questionable. In addition, the Facility's reported rationale regarding noncompliance was frequently very limited, and usually not based on the quality of the required documentation, but rather on singular issues such as timeliness. In addition, in some cases, the Facility's rationale for noncompliance was actually contradictory to the findings presented in the Self-Assessment. For example, the Facility indicated that one of the reasons it was not in substantial compliance with Section M.2 was due to nursing assessments not being timely completed. However, the data presented in the Self-Assessment indicated that from October 2011 through January 2012, 96% were completed within the specified time frame. In addition, many of the training activities that were cited in the Self-Assessment, and included in the Presentation Book for Section M did not contain a description, and/or curriculum for the training. Consequently, without this information, the Monitoring Team could not verify the quality of many of the training sessions. Also, as had been noted in past reports, in several areas for Section M, the documentation in the Self-Assessment reported a single compliance score for months of data, and tools with multiple items being measured. Consequently, these compliance scores were not meaningful, and did not accurately reflect the areas of strength, weakness, and the progress of the topics being reviewed. Although there was some improvement, the Facility Self-Assessment continued not to address all of the requirements for a number of the subsections of Section M of the Settlement Agreement. For example, very little information was included in the Facility's Self-Assessment regarding the individuals who had been hospitalized due to changes in their health status. In addition, the Facility Self-Assessment findings were not connected to the action plans and interventions the Facility planned to implement and accomplish by the next review. Also, the Action Plans for each Section of M were often generic, and did not clearly indicate how problematic areas would be addressed. Overall, in the Facility's Self-Assessment and the Provision Action Information, little information was

	provided regarding the Facility's positive steps forward in many areas. Instead, these had to be extracted from other information such as the minutes of meetings, or from the interviews conducted on site.
	Summary of Monitor's Assessment: Since the last review, LBSSLC had some changes in its Nursing Department and nursing positions, which included filling the newly established position for the Case Manager Supervisor, and experiencing some turnover in the Registered Nurse (RN) positions. In addition, the Nursing Department had a total of 96 allotted positions for nurses. Nursing vacancies included seven RN position, and five LVN positions. Although the Nursing Department had experienced some degree of nursing turnover, the Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions. Some of the Facility's positive steps forward included: ▪ In November 2011, the QA Nurses and the Nursing Department reduced the number of monitoring tools completed each month in an effort to focus on areas of greatest need that included Medication and Documentation, Urgent Care and Hospitalizations, Annual and Quarterly Nursing Assessments, Documentation, Nursing Care Plans, and Infection Control. ▪ In January 2012, the QA Nurses and the CNE began meeting monthly to discuss monitoring activities. ▪ Although not formally integrated into the instructions of the monitoring tools yet, the QA Nurse had begun to use the nursing protocols when auditing the nursing documentation in effort to address the quality of the nursing documentation. ▪ The construction and data entry regarding the Facility's immunization database was completed. ▪ In January 2012, the IC Nurse and a QA Nurse implemented a Real Time Audit for Acute Infections. ▪ The Facility implemented the Medical Emergency Response Drills Weekly Report that summarized relevant data regarding the drills conducted for the week. ▪ The Facility had continued to conduct drills in alignment with the Facility policy, and had added the areas of Food Service and Maintenance to the drill schedule. ▪ In an attempt to decrease the number of unexplained medications returned to the pharmacy, the Facility initiated a pilot program that consisted of separating the seven-day refilled medications by shifts to reduce the number of medications that were contained in one medication drawer. Due to the success of this pilot, this system was expanded to other residences. ▪ The Facility initiated the weekly monitoring of the Medication Administration Records (MAR) by the RN Unit Managers due to the large number of MAR blanks left unsigned by the nurses administering medications. The Facility data indicated that from December 2011, to January 2012, the number of MAR blanks had decreased by 219 to 21, a 91% reduction. ▪ In effort to decrease medication variances related to medications being given to the wrong individual, at the time of the review, the Facility was in the process of implementing a very promising pilot project using an identification card for each individual. Direct support professionals would present it to the nurse for comparison to the individual's picture on the MAR as an additional safety step to ensure the right individual was receiving the right medications. Although the Facility had made some positive steps in the areas noted above, of most concern was the lack

	of overall progress made in critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in health status, the quality of the quarterly/annual comprehensive nursing assessments, and the nursing documentation regarding individuals who transitioned into the community. These findings were consistent with the findings from the past four reviews, and no specific plan appeared to be in place to address these critical areas. In addition, although some promising steps forward were made regarding the Facility's medication administration system, at the time of the review, a number of significant problematic issues continued to exist, such as unexplained medications returned to the Pharmacy indicating that a number of doses were not administrated as ordered, underreporting of medication variances, and the lack of integration of the physical nutritional management plans into the administration of medications.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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, 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. A review of the Facility's Self-Assessment indicated the following: ▪ From review of data, the Facility found that its fill rates for nursing positions from 10/1/11 through 2/1/12 was on average 91.6%. Although this was a positive finding regarding the staffing for nursing, there was no explanation provided in the Self-Assessment indicating how this percentage was determined. ▪ The Facility reported that a review of the data generated from the Acute Illness and Injury Health Monitoring Tool for 18 individuals from November 2011 to January 2012, found: "49% compliance rate for documenting assessments, 60% compliance rate for Identifying health problems, 75% compliance rate for physician notification, and 30% compliance rate in monitoring problems." In addition, the Facility reported that a review of the data generated from the Documentation Monitoring Tool found: "15% compliance rate in documenting health issues, following-up the status of the problem, documenting action taken, response to treatment at least once per day until resolved and 50% compliance for the reason of the treatment and expected outcomes." However, there was no description contained in the Facility's Self-Assessment regarding how these 18	Noncompliance

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		individuals were selected for review, what the established inter-rater reliability percentages were for the audit tools, what specifically the compliance percentages reflected, and how they were determined. In addition, as had been noted in past reports, reporting single compliance scores for months of data is meaningless, and does not accurately reflect the areas of strength, weakness, and the progress of the areas being reviewed. Consequently, the Facility's data could not be accurately interpreted or considered reliable. ▪ In addition, the Facility reported that a review of the nursing tracking system to determine if timely filing of documents in the record was occurring found that from November 2011 to January 2012, 3,178 out of 3,362 (95%) were filed within the specified timeframe. Although a very positive finding, and in alignment with the overall improvement the Monitoring Team found while reviewing records on site, compliance data should be provided by month in order to adequately assess the progress made over time. Also, the CNE reported that in order to provide the numbers demonstrating compliance regarding timeliness of filing, the data was "hand counted," which he reported was a lengthy process. Automating these data or monitoring a percentage of documents monthly for timeliness would make the findings addressing these data more available, and less time intensive to aggregate. ▪ The Facility's Self Assessment indicated the since systems recently were implemented, no data were available to review the "Real Time" monitoring of infections to determine if treatment was provided that complied with standards of care. ▪ In addition, the Facility reported that no corrective actions were developed from an analysis of the infection control data, since the system was still under development. ▪ The Facility reported that a review of the Facility's immunization database was conducted to determine if all individuals' immunizations were current. However, the Facility reported that 221 of 221 (100%) individuals' immunization records had been reviewed and were being entered into the immunization database, which did not address the issue regarding whether or not they were current. ▪ Regarding Life Threatening Drills, the Facility reported that a review of the Drills from 10/13/11 to 1/7/12 found that 79 out of 81 (98%) drills included participation from nurses. However, no explanation was provided as to why only this time frame was used. In addition, this data also was presented using a single compliance score to represent three months of data. It also was unclear why additional data regarding staffs' performance during the drills was not included in the Self-Assessment. ▪ The Facility reported that it conducted a review of QA/QI meeting notes to verify that quarterly Life Threatening Drill analyses were reviewed. It found that the	

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		minutes from 10/24/12 to 1/12/12 reflected: "Life Threatening Drills were reviewed 1 out of 1 quarters." However, the Monitoring Team could not interpret these data. The Facility's Self Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because compliance rates are not at acceptable rates and further monitoring for some areas is still in the developmental stages." Although the Monitoring Team's finding of noncompliance comports with the Facility's rating, as noted above, much of the data presented in the Facility's Self Assessment could not be accurately interpreted. In addition, the Facility included a bulleted list of topics along with training rosters entitled: "Nursing Meeting" in the Presentation Book for Section M. However, no specific description was provided regarding how the training was provided. Without this information, the Monitoring Team was unable to determine the quality of the training that was provided. <u>Staffing</u> At the time of the review, LBSSLC had a census of 220 individuals. Since the last review, LBSSLC had some changes regarding its Nursing Department and nursing positions, including: ▪ In February 2012, the newly established position for Case Manager Supervisor was filled; ▪ Some turnover had occurred in the Registered Nurse (RN) positions; and ▪ The Nurse Educator Assistant had returned to work from an extended leave. At the time of the review, the Nursing Department had a total of 96 allotted positions for Nurses. Nursing vacancies included seven RN positions, and five Licensed Vocational Nurse (LVN) positions. Although the Nursing Department had experienced some degree of nursing turnover, especially regarding the RN positions, the Chief Nurse Executive reported that the Facility had continued to not use the services of any agencies to cover nursing positions, and had been receiving some promising applicants. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive, despite the turnover in positions, LBSSLC continued to maintain an adequate nursing staff. In efforts to recruit nursing staff, the CNE reported that in November 2011, he met with 29 graduating LVNs from South Plains College to present employment opportunities for nurses at LBSSLC. As recommended previously, although there had been some nursing turnover, which had stabilized at the time of the review, LBSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to	

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		meet the requirements of the Settlement Agreement. Also, as previously recommended, as LBSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of the new Case Manager Supervisor position. <u>Quality Enhancement Efforts</u> From discussions with the Quality Assurance Nurses, and review of the Provision Action Information report, since the last review, the following activities had been initiated: ▪ In November 2011, the QA Nurses and the Nursing Department reduced the number of monitoring tools completed each month in an effort to focus on areas of greatest need, including Medication and Documentation, Urgent Care and Hospitalizations, Annual and Quarterly Nursing Assessments, Documentation, Nursing Care Plans, and Infection Control. ▪ Although the Facility did not have an established procedure addressing inter-rater reliability, the QA Nurses and Nursing Department had begun conducting some of the nursing audits together to discuss audit findings and discrepancies regarding compliance scores in an attempt to assess inter-rater reliability. No information was provided addressing how the discrepancies were reconciled. At the time of the review, no minutes were recorded of these meetings. However, these efforts were a very positive step forward to ensure consistency between the auditors. ▪ In January 2012, the QA Nurses and the CNE began meeting monthly to discuss monitoring activities, and data. This was a very positive step forward. However, the minutes of these meetings indicated that thus far, the discussions were focused solely on the monitoring tools. There was no indication that the results of the auditing activities were being analyzed and discussed. ▪ Although not formally integrated into the instructions of the monitoring tools yet, the QA Nurse had begun to use the nursing protocols when auditing the nursing documentation. This was a very positive step forward in moving the Facility toward reviewing the quality of nursing documentation according to standards of practice for nursing, and should be integrated into the instructions for the monitoring tools. Although the Presentation Book for Nursing included some raw data from the audits, the CNE and QA Nurses reported that at the time of the review, there had been no formal reports or analyses conducted of the nursing data. The CNE reported that by the next review, this process would be initiated. As the Facility progresses regarding generating its data, and presenting its data, 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	

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		implemented. The integrity of this foundational framework will affect the determination of substantial compliance in most, if not all, clinical and non-clinical areas. To adequately and consistently monitor Section M of the Settlement Agreement, the Facility should ensure the following systems are adequately implemented: ▪ Although the Facility had developed and modified some of the instructions for the Nursing Health Monitoring tools, overall, the instructions were not clear and specific. For example, the current instructions did not consistently outline exactly where the required documentation should be found, and specifically what should be included in the documentation to meet compliance. In addition, in determining compliance, items addressing the quality of nursing documentation should be compared to quality standards, such as nursing protocols. The Facility had begun to do this, but it should be formalized in the instructions. Without clear and specific instructions for the monitoring tools, compliance would be determined according to each auditor's judgment, which 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. ▪ Inter-rater reliability should be established for each of the Health Monitoring tools to ensure 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. 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 auditing data, as noted in previous reports, it should include a description of the total population being reviewed (N), and a description of the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores. Also, data presented by item by month rather than by one single compliance score per tool for a quarter would provide essential information regarding the progress for specific areas being reviewed. A review of the QA Nurse and Nursing Department's raw audit data found that the problematic issues listed above rendered the data unreliable. However, implementing the structures listed above should facilitate the accuracy and reliability of the Facility's data. The Facility should implement the remaining essential pieces of the monitoring system to generate credible data going forward, and continue to give thoughtful consideration when prioritizing the implementation of the Health Monitoring audit tools based on the areas that affect the health and safely of the individuals at LBSSLC.	

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		Although the Facility had decreased and prioritized the number of Health Monitoring Tools it was using since the last review, the constant starting and stopping of auditing during the past two years had resulted in limited data being available, as well as a lack of systems to review and analyze the data. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ The Facility reported that since the last review, a total of 17 State Office Nursing Care Protocols had been implemented. Although the Facility reported that all nurses had received training regarding these nursing protocols, no description of the training was provided. The training roster indicated that the training lasted for ten minutes indicating that there had been minimal discussion of the protocols at best. Based on the Monitoring Team's findings noted below, no consistent improvement was seen in the nursing assessments, nursing Health Management Plans, and/or nursing documentation. In addition, no evidence was seen in the nursing documentation that the nursing protocols were actually being used to guide the development of Health Management Plans, the criteria and frequency of nursing assessment, and/or the documentation of nursing care. Thus, the training the Facility provided regarding the nursing protocols was inadequate. A review of 13 individuals' medical records (i.e., Individual #89, Individual #161, Individual #56, Individual #226, Individual #281, Individual #211, Individual #176, Individual #9, Individual #242, Individual #263, Individual #162, Individual #233, and Individual #309) 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%) of the cases reviewed. ▪ Licensed nursing staff timely and consistently 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 nurses consistently performed appropriate and complete assessments as dictated by the symptoms in none (0%) of the cases. ▪ The nurses conducted frequent assessments of the individual's clinical condition in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases.	

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		▪ 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 that essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past four reviews continued to exist. The overall problematic issues that were found in all 13 records included specifically: ▪ There was a chronic lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted regular nursing assessments and documentation of the findings from assessments; ▪ There was a chronic lack of complete and appropriate nursing assessments in response to status changes in vital signs, oxygen saturations, and other symptoms such as vomiting or coughing; ▪ The lack of consistent nursing documentation rendered it impossible to accurately determine when the changes in status initially occurred; ▪ There was a consistent lack of follow-up for health issues that were documented in previous nurses' progress notes; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of pro re nata medications (PRN, or as needed medications); ▪ There were consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The nursing notes lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was a chronic lack of documentation regarding individuals' activities and tolerance for activities during the day, evening, and night to indicate any associated changes in mental status related to physical changes in status; ▪ There were few mental status assessments documented during status changes; ▪ 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; ▪ There were significant gaps in nursing documentation indicating that nursing had not been assessing the individual, even when the nurses' notes indicated that changes in individual's status were occurring; ▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ There was a consistent lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the	

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		individuals; ▪ There were many inappropriate abbreviations found in the nursing notes that could not be interpreted; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow-up; ▪ There was inadequate documentation noted regarding the individual's status and assessment at the time of transfer to the hospital or emergency room; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was inadequate documentation 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; ▪ There were discrepancies found between Health Management Plans and PNMPs; ▪ Dates and times were not consistently documented for progress notes; ▪ A number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although sporadic, some of the Integrated Progress Notes contained an adequate nursing assessment, and associated findings. However, due to the chronic inconsistency of these notes, it was obvious that these were not the result of a structured system. Although the Facility reported that Nursing Protocols had been implemented, there was no indication that they were being used to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices, in conjunction with the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group. Despite the "live reviews" the Monitoring Team conducted during every review, consisting of reading the Integrated Progress Notes (IPNs) of an individual who had recently been hospitalized, and discussing with Facility staff the problematic issues found regarding the nursing assessments, Health Management Plans, and overall nursing documentation, no progress had been made in this critical area. Given the number of individuals with medical complexities at LBSSLC, the lack of appreciable progress, the	

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		inadequate training that was provided regarding nursing protocols, and the perceived lack of urgency and understanding regarding how these deficiencies in nursing care affect clinical outcomes was alarming. The Facility's Self-Assessment indicated that it was not in compliance with the elements of this requirement, which was consistent with the Monitoring Team's findings. <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. As noted above, the information contained in the Facility's Self Assessment indicted that as a result of systems implemented addressing the timely filing of documents into the active records, significant positive gains had been made regarding this issue. 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, an LVN assisted with duties related to employee health issues. From a review of the Facility's Self-Assessment, LBSSLC's Action Provision Information report, the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse, and information gathered during the review, positive steps continued to be made in building systems to meet the requirements of the Settlement Agreement. Some of the progress included: ▪ The Infection Control Nurse had collaborated with the RN Case Managers regarding researching and gathering information regarding immunizations. However, at the time of the review, this information had not been aggregated in order to provide information regarding which individuals' immunizations had been fully researched and updated. ▪ The Facility involved the Residential Coordinators in the completion of the Standard Precaution Monitoring tool. From discussions with the IC Nurse, this addition had positively increased communication between the disciplines regarding infection control issues. ▪ The IC Nurse provided training to the Foster Grandparents regarding proper hand washing, and basic infection control principles. This was a very positive step since employees, visitors, and family members can bring many of the infectious processes into the Facility. In addition, providing this basic training to the Forster Grandparents should assist in the prevention of the spread of the infectious illness.	

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		▪ The Facility's immunization database was implemented. At the time of the review, the Facility had completed the entry of the existing data for immunizations. In addition, a spreadsheet was implemented for the Case Managers to add data to when information regarding immunizations was updated. However, the IC Nurse reported that the State's database would be available within the next six months, and that all the data would have to be manually transferred from the Facility's current database and into State's database; ▪ The documentation regarding infectious outbreaks since the last review provided clear and specific information regarding the date and time when issues were discovered, and when actions were implemented. The increase in specific information should assist the Facility in evaluating areas of strength and weaknesses regarding its responses to outbreaks, and implementing corrective actions. ▪ From discussions with the IC Nurse, observations of an Infection Control Committee meeting, and review of the documentation provided to the Monitoring Team, there was solid evidence of increased collaboration and communication between the IC Nurse, the Pharmacy Department, nurses at the residences, direct support professionals, medical staff, QA Nurses, and Residential Coordinators regarding infection control issues. ▪ The Monitoring Team noted continued improvement regarding the structure, and content of the Infection Control Committee meeting minutes. Specifically, the analysis of the IC data continued to increase, and more discussions occurred regarding the monitoring of employees' health and the effects it had on the spread of infections at the Facility. ▪ The Facility continued to track and reconcile discrepancies regarding the IC data to ensure the reliability of the data. ▪ In January 2012, the IC Nurse and a QA Nurse implemented the Real Time Audit for Acute Infections. ▪ A number of appropriate and timely in-service training sessions were provided to staff in response to infectious outbreaks, and acute infectious illnesses. Although the Facility had made several positive steps forward, a number of systems addressing clinical issues and outcomes needed further attention, including; ▪ As noted above, an immunization database was implemented, and was now being regularly updated. However, at the time of the review, the IC Nurse could not readily identify those individuals who Case Managers had not yet researched regarding the documentation of past titers obtained, and immunization status as outlined in the Health Care Guidelines. A formalized immunization list should be compiled from the database to easily track the progress regarding this area. ▪ Although the Facility involved the Residential Coordinators in the	

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		implementation of the Standard Precaution Monitoring tool, the results of these audits should be included in the minutes of the Infection Control Committee meeting minutes in order to aggregate and analyze these data in conjunction with the other IC data. ▪ Regarding Nursing Care Plans, essentially the same problematic issues were found during this review as were found during the previous reviews. Specifically, a review was conducted of 26 episodes of various infectious illnesses for 22 individuals (i.e., Individual #23, Individual #237, Individual #250, Individual #103, Individual #184, Individual #136, Individual #176, Individual #312, Individual #199, Individual #324, Individual #53, Individual #201, Individual #77, Individual #161, Individual #225, Individual #6, Individual #196, Individual #75, Individual #263, Individual #209, Individual #56, and Individual #78) to determine if appropriate care plans to address their needs had been developed. (Individuals that had more than one infectious episode included: Individual #196, Individual #6, Individual #225, and Individual #199.) Of the 26 episodes, only 15 (58%) were found to have had Health Management Plans (HMPs) addressing the infectious issue. Of the 15 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. ▪ In addition, a review of the HMPs addressing infectious illnesses regarding outbreaks of gastroenteritis in November 2011, respiratory symptoms in November 2011, scabies in December 2011, and gastrointestinal (GI) symptoms in February 2012 found that only the individuals diagnosed with scabies (i.e., Individual #226, Individual #258, Individual #21, Individual #62, and Individual #89) had HMPs addressing the specific outbreak symptom. Of these five HMPs reviewed, none (0%) were adequately individualized, and, therefore, were not considered clinically 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 and consistently implemented. ▪ Although at the time of the review, only seven Real Time Infection audits had been completed, the initial findings included some very relevant clinical issues. These included nursing care plans not being implemented for acute infections, proper precautions not timely implemented, staff not consistently washing their hands after interactions with infectious individuals, dirty gloves not appropriately disposed of, and some supplies, such as gloves, not consistently stocked for staff use. Discussions with both the QA Nurse, and IC Nurse indicated that they were surprised and concerned regarding the problematic issues that they observed while conducting the Real Time Infection audits. However, the insight gained from conducting these audits should assist the IC Nurse and the Nursing Department in identifying areas in need of prompt	

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		attention to protect the individuals and staff from the spread of infectious illnesses. The Facility should continue to focus its efforts on the implementation of the clinical Real Time auditing tool to assess the clinical practices and treatments of infectious and communicable diseases. In addition, IC staff should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. As the Facility recognized with these initial reviews, 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. ▪ Although from review of the Infection Control Committee meeting minutes, the Committee had increased its analysis of the some of the Facility's IC surveillance data, more clinical analysis was needed regarding the current data, such as any associated trends regarding the organisms found from the cultures, the units that experienced the most frequent occurrences, comparisons of quarterly data for 2012 to the same quarter in 2011, and overall Facility trends in infections. In addition, integrating the findings of the Real Time Infection audits with the current IC data should produce additional actions steps to be implemented in addressing some of the problematic trends identified. Since the last review, the Facility had made a number of impressive steps forward with regard to Infection Control. Of special note, the gains in understanding and knowledge of the IC Nurse regarding the need to monitor the infection control practices of the Facility, and implement systems addressing these areas had been exceptional. However, a significant amount of work was yet to be done regarding ensuring safe and appropriate clinical practices addressing infection control issues in meeting the requirements of the Settlement Agreement. As previously recommended, 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 Facility's overall Infection Control Program. <u>Mock Code Drills and Emergency Response Systems</u> From review of the Facility's Self-Assessment, Provision Action Information Report, and interviews with the CNE, and Competency Training Department staff, some progress had been made including the following: ▪ The Facility implemented the Medical Emergency Response Drills Weekly Report that summarized the drills conducted for the week. This included information regarding where they were conducted, on what shift, if all required direct support professionals and health services staff attended, if the emergency equipment was brought to the drill and if it was in good working condition, the number of failed drills, problems identified, and the corrective action and date	

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		initiated. This was a very positive step forward in aggregating data regarding the drills in order to easily identify problematic issues on a weekly basis, rather than waiting a month to discover an issue that might need immediate attention. ▪ In January 2012, the Nurse Educator Assistant began emergency equipment training for nurses at the residences. A tracking schedule was initiated to ensure that all nurses received this training every quarter. ▪ Since the last review, the Facility had acquired eight new Automated External Defibrillators (AEDs) and backboards. ▪ The Facility had continued to conduct drills in alignment with the Facility policy. Since the last review, it had added the areas of Food Service, and Maintenance to the drill schedule. ▪ Data from the Facility indicated that nursing staff had an increase in attendance and participation in the drills. ▪ In December 2011, Risk Management began monthly checks of the Emergency Equipment in alignment with the State Office policy. ▪ Based on the Monitoring Team's observations of the Nurse Educator Assistant while she assessed the competency of nurses regarding the use of the emergency equipment, the content of the information she was requiring from the nurses was comprehensive, and the audits were very professionally conducted. Although the Facility implemented some positive steps addressing the Emergency Response System, a number of problematic issues were found that should be addressed in order for additional progress to be made: ▪ From discussions with the CTD Director, the AEDs that were used for the drills were test AEDs that the CTD instructors brought to the drills. The Facility should give consideration to implementing a system where staff is required to actually go to the location of the closest AED in order to demonstrate knowledge regarding where the closest AED is kept, as would be the case in an actual emergency. ▪ A review of the newly implemented Medical Emergency Response Drills Weekly Reports indicated that a number of the reports either had blanks regarding the corrective action and date completed, or insufficient information regarding the specific action taken when a problem was identified and noted in the report. ▪ Although the minutes of the Incident Management Review Team meetings included the Medical Emergency Response Drills Weekly Reports, virtually no discussion or analysis was found regarding this information. In addition, no discussion or analysis was found related to the findings from the Risk Management monitoring data regarding emergency equipment, Nurse Educator observation data regarding emergency equipment use, or actual emergencies that occurred to identify areas of strengths and weakness in the Facility's emergency systems.	

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		▪ Although the CTD staff indicated that some physicians also were responding to and participating in the drills, the monitoring data regarding Emergency Response Drills from Risk Management indicated that from October 2011 through February 2012, no medical provider attended the drills. The Monitoring Team's observations of RNs demonstrating the emergency equipment at Quail indicated significant improvement in staff's knowledge and ability to demonstrate the use of the emergency equipment. However, although the Facility's data regarding the pass rate of the Emergency Response Drills from October 2011 through February 2012 was 100%, the Monitoring Team's observations of nurses demonstrating the emergency equipment at Sparrow and Fir indicated that problematic issues continued to exist regarding nurses' ability to use the emergency equipment at the residences. The Monitoring Team's findings included: ▪ The LVN in Quail needed significant prompts regarding the demonstration of the suction machine, and citing oxygen flow rates. ▪ The LVN at Fir required significant prompting while demonstrating the use of the suction machine, and citing oxygen flow rates. This LVIN was not able to demonstrate how to turn on the AED, and was not aware if the residence had back-up oxygen available in the event the initial tank was inoperable or empty. In addition, while on site, the CNE requested that the AEDs not be turned on for fear that they would be accidentally discharged. However, observing an LVN not knowing how to turn on an AED indicated that bypassing this crucial step while conducting observations of demonstrations of emergency equipment use rendered the observations unreliable, and clearly did not reflect competency regarding emergency equipment use. Although LBSSLC had made some positive steps forward regarding its Emergency Response System, the Facility needed to address the number of problematic issues noted above. The Facility should review all data related to its emergency systems, including information from actual medical emergencies, and analyze the findings to ensure that all areas of the Facility's emergency systems are being adequately addressed, and that any training provided translates into improved practices. The Facility's Self Assessment indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a	In assessing its progress, in the Facility's Self-Assessment, LBSSLC indicated that since the last review, it had taken a number of steps regarding this requirement of the Settlement Agreement. However, as noted below, the Monitoring Team had concerns about the data provided: ▪ The Facility reviewed data to determine if Quarterly/Annual Comprehensive Nursing Assessments were completed for all individuals, and found that from	Noncompliance

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	quarterly basis and more often as indicated by the individual's health status.	October 2011 through January 2012, 226 out of 229 (99%) were completed. However, there was no indication what specific criteria was used to determine completion, if both quarterly and annual comprehensive were included in these data, and how this data was different from the data presented below regarding completion. ▪ Additionally, the Facility reviewed data to determine if Quarterly/Annual Comprehensive Nursing Assessments were completed within 10 business days prior to the ISP, and found that from October 2011 through January 2012 that 219 out of 229 (96%) were completed within the specified time frame. Although the Presentation Book for Section M contained a copy of a tracking tool for the Comprehensive Nursing Assessments, no data was provided verifying these compliance scores from the Facility. In addition, it was unclear as to why the total population, 229, was included in the sample, since all individuals would not have had an ISP between the October 2011 and January 2012. Thus, the Facility's data could not be accurately interpreted and compared to the findings of the Monitoring Team's. ▪ The Facility's Self Assessment indicated that since the system had not been developed, there was no data to review to determine individuals' status and need for updated assessment following hospitalizations, new medical diagnosis, surgical procedures, change in health status, and change in level of functioning. The Facility's Self Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance as assessments are not completed timely and a system to monitor changes in health that determine the need for updates has not yet been developed." Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the review that justified the Monitoring Team's finding of noncompliance, as detailed below, was far more extensive. It addressed the quality and content of the Comprehensive Nursing Assessments, as opposed to just timeliness issues. Thus far in the review process, LBSSLC was not generating findings addressing the quality of the documentation contained in the Comprehensive Nursing Assessments, which continued to be inadequate. In addition, no explanation was provided regarding why the Facility's Self Assessment indicated that the assessments had not been timely completed when the data reported by the Facility suggested otherwise. In addition, the Provision Action Information for Section M indicated that the following steps were taken in addressing this requirement: ▪ In December 2011, the CNE met with the Nurse Operations Officer (NOO), and the RN Case Managers to discuss, and develop an Action Plans for M.2. A review of this Action Plan found it addressed the timeliness of the completion of the	

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		Comprehensive Nursing Assessments with little focus on improvement of the quality of the assessments. Although the Action Plan indicated that competency-based training regarding the completion of the assessments was "in process," no curriculum was provided in the Presentation Book in order for the Monitoring Team to review the appropriateness of the content, and the method of determining competency. ▪ In January 2012, the Facility developed and implemented a tracking tool to ensure that the Comprehensive Nursing Assessments were completed and filed 10 days prior to the IDT meeting. A review of the tracking spreadsheet found that when reviewed regularly, it was a positive step forward in quickly identifying problematic trends regarding timeliness of completion of the assessments. ▪ Also, in January 2012, the Case Managers met and were provided an example of a Comprehensive Nursing Assessment. This was an attempt to provide information about how to organize the summary information addressing the individuals' health issues. However, a review of the example found it to be an inadequate example of an analysis of an individual's healthcare issues. In addition, no training rosters or explanation were provided to describe what specific method was used to assess the Case Managers' ability to synthesize, and analyze clinical information to adequately complete a nursing summary for the Comprehensive Nursing Assessments. Due to the consistent significant problems found over the past reviews regarding the quality of the Comprehensive Nursing Assessments, it was troubling to find inadequate training material being used as an example of appropriate documentation. ▪ In a very promising move forward, in February 2012, the Facility hired a full-time RN Case Manager Supervisor to oversee the RN Case Managers to ensure that they are timely and appropriately executing their duties. The introduction of this new statewide position should increase the accountability of the crucial role of the RN Case Managers. From discussions with the CNE, since the last review, some state-wide modifications had been made to the Quarterly/Annual Comprehensive Nursing Assessment form that included the addition of the Braden Scale regarding skin integrity, categories for discussion in the Summary Section, and statements regarding the supports and services provided by nursing and in relation to potential transition to the community. Although these were positive modifications, the Monitoring Team found that there had been little to no progress made regarding the quality of the quarterly/annual nursing assessments. In fact, a number of the Comprehensive Nursing Assessments reviewed contained significantly less information in the Summary Section than noted during the last review. The Quarterly/Annual Nursing Assessments for 22 individuals, who the Facility	

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		identified as being at risk for specific health indicators were reviewed, including those for: Individual #116, Individual #56, and Individual #130 for osteoporosis; Individual #45, Individual #154, Individual #38, and Individual #111 for dental issues; Individual #270, Individual #281, and Individual #174 for urinary tract infections; Individual #245, Individual #80, and Individual #23 for constipation; Individual #120, Individual #322, and Individual #184 for falls; Individual #306, Individual #264, and Individual #86 for challenging behavior; and Individual #13, Individual #304, and Individual #276 for cardiac issues. Based on this review, the following findings were made: ▪ Of the 22 individuals' nursing quarterly assessments reviewed, 18 (82%) were timely completed. Assessments that were not timely completed included Individual #304, Individual #276, Individual #281, and Individual #264. ▪ 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 and medium 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. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an appropriate analysis of the individuals' health/mental health issues between quarters. Despite the changes made in the format of the Summary Section, the summaries were essentially a listing of sequential data, and/or dates of events, such as hospital admissions, with no associated analysis indicating if the health issues were improving or getting worse. The chronic lack of progress regarding the Comprehensive Nursing Assessments coupled with the inadequate training example noted above, and the Facility's lack of a concrete plan to adequately address this requirement suggested that nursing at all levels within LBSSLC lacked the ability and understanding regarding how to analyze, summarize, and document health/mental health issues to determine whether or not progress was being made regarding individuals' health and behavioral issues. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the Nursing Discharge Summaries for three individuals including: Individual #173, Individual #166, and Individual #48 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the	

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		health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted for none (0%) of the individuals prior to discharge/transferring to the community. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. Nursing should provide a clear and comprehensive analysis summarizing the individual's health/mental health issues since they have been at the Facility, as well as their current status. This should be available from the summaries from the Quarterly/Annual Comprehensive Nursing Assessments. In addition, Nursing Care plans addressing all health issues, including individual-specific nursing interventions the individual needs should be provided to the receiving staff. Also, a summary of the goals and progress of any nursing programs should be included in the documentation for transition/discharge. As found during past reviews, the problematic issues regarding the nursing assessments for discharges/transitions to the community had not been addressed with the implementation of a new state-wide form. In addition, due to the poor quality of the Health Management Plans (as discussed with regard to Section M.3), no nursing documentation was found that provided any specific guidance regarding the type and frequency of nursing interventions that the individuals required. From discussions with the CNE, the Facility had no plan in place to address this area by the next review. Unfortunately, there appeared to be a lack of recognition that the more information the Facility provided to the community staff regarding an individual's health/mental issues, the greater the potential for consistency in care, and a successful transition. It is essential that LBSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individuals' discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. Again, the problematic issues found by the Monitoring Team during this review were consistent with the findings from previous reviews with no progress noted. Overall, the same problematic issues were found in all the Comprehensive Nursing Assessments reviewed as noted from the previous reviews that included: ▪ A significant lack of clinical assessments for clinical health indicators; ▪ A lack of an analysis of the individuals' health/mental health issues; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments; and ▪ A lack of a comprehensive and specific nursing assessment for individuals being	

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		discharged/transitioned to the community. The Facility's Self Assessment 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.	LBSSLC indicated in the Facility's Self-Assessment that since the systems addressing this requirement were in the developmental stages, no data were available to address the following activities in evaluating compliance: ▪ Review of quarterly and annual assessments to determine if individuals' health care needs were appropriately assessed; ▪ Review of integrated risk tools to determine utilization of assessments to properly evaluate risks; ▪ Review of quarterly/annual assessment summaries to determine past, present, and future plans of care for identified health care issues; and ▪ Review of data to determine whether interventions the RN Case Manager developed are implemented promptly. The Facility's Self Assessment indicated that "based on this self-assessment, this provision is not in substantial compliance as monitoring has not been developed and implemented to monitor for compliance." In addition, the Provision Action Information for Section M.3 indicated the following: ▪ In December 2011, the NOO, and Unit Managers met to coordinate Action Plans for Section M.3. However, discussions with the CNE, and documentation contained in the Facility's Self Assessment indicated that these action plans were recently modified from the initial plan that included establishing a committee to develop an integrated health care plan format to the recently established Risk Workgroup described with regard to Section I.1. Although the function of the Risk Workgroup regarding addressing the Facility's risk system was a positive initiative, it was not clear why the establishment of this workgroup precluded nursing from actively addressing the problematic issues consistently found during past reviews regarding the Nursing Care Plans/Health Management Plans. Collaborating and working in tandem regarding clinical and systemic issues with the Facility's Risk Workgroup is, without question, essential. However, the development of clinically appropriate nursing care plans addressing individuals' health issues is a basic professional function of nursing. The continual delays in addressing this fundamental and critical element in conjunction with the lack of explanation from Nursing regarding the barriers to forward movement were very troubling. ▪ In February 2012, the Facility reported that the RN Case Managers conducted initial monitoring for individuals receiving enteral feedings. The Facility	Noncompliance

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		reported that 32 of 39 individuals were monitored, and the findings demonstrated that individuals were properly positioned, nutrition orders were congruent with treatment records, pumps and poles were cleaned, and that direct support professionals and nurses were familiar with the rationale for receiving enteral feedings and the dangers of not following the Physical Nutritional Management Plans. However, no information was provided regarding if and how the RN Case Managers were trained regarding the monitoring criteria, if inter-rater reliability was established, and if the Physical Nutritional Management Team was involved in the process. In addition, no specific percentages of compliance were provided by item from the auditing results. This information needed to be included in the Presentation Book for Section M, especially because the Facility's reported findings did not comport with the overall findings of the Monitoring Team, as discussed with regard to Section M.6. Also, discussion with the CNE and ADOP indicated that in November 2011, the IDT from 504 E. Mesquite had met and developed integrated care plans for six of their most medically complex individuals (i.e., Individual #6, Individual #136 Individual #29, Individual #263, Individual #225, and Individual #215). Although a review of these integrated care plans found them promising, the ADOP candidly reported that significant system and discipline barriers resulted in poor follow-thorough regarding the interventions contained in the care plans. Unfortunately, at the time of the review, the plans had not been adequately implemented. The records of 22 individuals, who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #116, Individual #56, and Individual #130 for osteoporosis; Individual #45, Individual #154, Individual #38, and Individual #111 for dental issues; Individual #270, Individual #281, and Individual #174 for urinary tract infections; Individual #245, Individual #80, and Individual #23 for constipation; Individual #120, Individual #322, and Individual #184 for falls; Individual #306, Individual #264, and Individual #86 for challenging behavior; and Individual #13, Individual #304, and Individual #276 for cardiac issues. Of the 22 individuals' Health Management Plans reviewed: ▪ Seven (32%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #174, Individual #80, Individual #23, Individual #120, Individual #322, Individual #86, Individual #13, Individual #304, and Individual #276. ▪ None (0%) of the goals listed in the seven HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the seven HMPs indicated	

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		who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the seven HMPs were found to be clinically adequate. ▪ None (0%) of the seven HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the seven HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in the seven HMPs, validating the implementation of the interventions was not possible, rendering the HMPs inadequate as guides for the provision of care. Consistent with the findings from the previous reviews, LBSSLC's Nursing HMPs continued to lack the following key elements: ▪ Clinically appropriate nursing diagnoses/goals/objectives related to the etiology of the identified health/mental health problems. For example, Individual #45's IDT identified the individual as being at high risk for dental concerns due to appointment refusals and oral hygiene issues. The Nursing Care Plan addressing refusals for appointments and medications contained the following inappropriate Nursing Diagnosis: "Ineffective Denial related to threat of unpleasant reality as evidenced by lack of concern regarding participation in important doctor's appointment, and refusing medications." The nursing care plan contained mainly generic nursing interventions, such as encourage compliance with appointments and medications, without mention of his high risks regarding dental appointment refusals. However, the most individualized intervention contained in the care plan stated to provide the individual with a "mini 3-Muskateers bar," when compliant with medications. This nursing care plan clearly demonstrated that little thought was given as to the individual's health risks; ▪ Specific interventions addressing health risk indicators; ▪ Proactive interventions directed at preventing or minimizing the specific health risks; ▪ Individual-specific interventions based on the individuals' needs; and ▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues. In order for the Facility to make progress regarding this provision of the Settlement Agreement, the Health Management Plans should be: • In alignment with standard nursing protocols; and • 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	

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		implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom. It is essential that the Facility address the lack of clinically adequate HMPs for the individuals under their care. The Facility should actively and aggressively begin to develop and implement appropriate HMPs for all individuals at LBSSLC based on priority, and risk. Regarding HMPs addressing infectious illness, the Facility reported that since the last review, there had been outbreaks of gastroenteritis in November 2011, respiratory symptoms in November 2011, scabies in December 2011, and gastrointestinal (GI) symptoms in February 2012. From review of the documentation the Facility provided in response to the Monitoring Team's request for the nursing care plans for all individuals affected by the outbreaks, the Monitoring Team could only validate that the individuals diagnosed with scabies (i.e., Individual #226, Individual #258, Individual #21, Individual #62, and Individual #89) had nursing care plans addressing the specific outbreak symptom. ▪ Of the five Nursing Care Plans reviewed addressing the infectious/contagious disease, none (0%) were adequately individualized to be considered clinically adequate; and ▪ For the individuals affected by the outbreaks of gastroenteritis in November 2011, respiratory symptoms in November 2011, and GI symptoms in February 2012, none (0%) were found to have had HMPs addressing the infectious issue. In addition, a review was conducted of 26 episodes of various infectious illnesses for 22 individuals (i.e., Individual #23, Individual #237, Individual #250, Individual #103, Individual #184, Individual #136, Individual #176, Individual #312, Individual #199, Individual #324, Individual #53, Individual #201, Individual #77, Individual #161, Individual #225, Individual #6, Individual #196, Individual #75, Individual #263, Individual #209, Individual #56, and Individual #78) to determine if appropriate care plans to address their needs had been developed. (Individuals that had more than one infectious episode included: Individual #196, Individual #6, Individual #225, and Individual #199). Based on this review: o Of the 26 infectious episodes, only 15 (58%) were found to have had HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #75 for MRSA; Individual #196 for MRSA; Individual #6 for MRSA; Individual #225 for two episodes, including MRSA and C-diff; Individual #56 for MRSA; Individual #250 for conjunctivitis; Individual #184 for conjunctivitis; Individual #312 for conjunctivitis; Individual #324 for conjunctivitis; and Individual #53 for conjunctivitis. o Of the 15 Nursing Care Plans reviewed addressing infectious diseases, none	

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		(0%) were found to be adequate. In fact, the findings demonstrated that since the last review, there appeared to be a decrease in the attempts to individualize the templates the Facility used. Overall, some of the deficiencies noted in the HMPs reviewed included: ▪ The significant lack of individualization of the HMP template; ▪ 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; ▪ Inappropriate goals that did not address the prevention of the spread of the infectious illness; ▪ The lack of specific interventions addressing teaching and education for staff, as well as the individual regarding the prevention of the spread of the infection; and ▪ The lack of proactive interventions found for individuals that had repeated infectious episodes. Consistent with previous findings, LBSSLC had no system 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. The absence of HMPs as well as the decrease noted in overall attempts to individualize the HMPs indicated that not only was the Facility not making progress in this area, but also actually was falling backwards. As noted in past reports, it was very alarming to find that individuals with contagious/infectious illnesses, such as conjunctivitis, MRSA, and C-diff, either did not have HMPs or had inadequate HMPs addressing these illnesses. The Nursing Department, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that all individuals experiencing infectious illnesses have a clinically adequate, individualized HMP addressing the infectious illness and that they are being implemented consistently. From discussions with the Infection Control Nurse, and as discussed in further detail with regard to Section M.1, Infection Control, the Facility had implemented a monitoring system for acute infections that was conducted at the time the infection was active. Although the system only recently had been initiated, the IC Nurse reported that a number of problematic issues were initially identified regarding the implementation of safe staff practices for individuals with acute infections. Although this was a very positive step forward in enabling the Facility to begin to be able to identify problematic trends in the clinical practices surrounding infectious and contagious processes, these initial findings coupled with the chronic lack of clinically adequate nursing care plans addressing infections should sound an alarm regarding the urgency with which attention should be paid to this area.	

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		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 in all Health Management Plans. In alignment with this collaboration, 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 risks 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.	Based on a review of LBSSLC's Self-Assessment, the Monitoring Team found the following: ▪ The Facility reported that a review of Integrated Progress notes from 2/6/12 to 2/10/12 reflected that: "9 out of 28 (68%) assessments followed appropriate protocols." Although the Facility's compliance percentage was incorrect, and should have been 32%, additionally, there was no explanation regarding what specifically the "9 out of 28" assessments represented, such as the assessments for one individual for four days, or did this data represent a sample of individuals. In addition, no data were provided regarding what specific criteria was used to determine compliance, who conducted the audit and were they clinically competent in the area that was being reviewed, what monitoring tool was used, were instructions developed, was inter-rater reliability established among auditors, and why did the auditing timeframe only consist of four days. Consequently, the Monitoring Team could not accurately interpret the data the Facility presented. The Facility reported that "based on this self-assessment, this provision is not in substantial compliance as nurses are not consistently using the nursing protocols for assessing and documenting medical problems." A review of the information provided in the Provision Action Information for Section M.4 indicated that training had been provided regarding the new Dental/Medical Sedation policy, the Restraint policy, the new Automatic External Defibrillators (AEDs), and eight new statewide nursing protocols. However, the training rosters that were included in the Presentation Book for Section M for these trainings did not indicate how many staff were required to attend, and how many of those actually attended to provide a percent compliance. In addition, no descriptions were included of how the material was presented. Thus, there was no way to determine the quality of the training, such as if the training consisted of a discussion of the policies and protocols, or if staff just read the material and then signed the rosters. For example, the training roster for the nursing	Noncompliance

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		protocols noted that the training lasted for 10 minutes. Although this suggested that there was very little discussion regarding the protocols, there was no curriculum included describing what actual training was provided. In addition, it was very troubling that such a short time was spent on a critical area that affects the nursing care of individuals and its associated documentation. There was no indication that that any training was provided or was going to be provided regarding the use of nursing protocols in the development of nursing care plans. In addition, the Provision Action Information indicated that to ensure that nursing protocols were being used, the RN Case Managers were to review the documentation for individuals that were transferred to the hospital. However, no information was provided regarding what specific criteria was used to determine compliance, how the auditors were determined to be clinically competent in the area that was being reviewed, whether a monitoring tool was developed addressing this area, whether instructions were developed for the tool, and whether inter-rater reliability had been established among auditors. Although monitoring the use of nursing protocols in the nursing documentation is crucial, the structure of this system needs to be thoughtfully and appropriately constructed in order for the accurate data to be generated, and appropriate feedback provided to nursing staff. From discussions with the CNE, the Facility had implemented the initial State Office nursing protocols in November 2011, and an additional eight in February 2012. At the time of the review, the Facility had a total of 17 statewide nursing protocols. However, as mentioned above, the training regarding the protocols was extremely brief and not competency-based regarding the role of the protocols in the development of nursing care plans and nursing documentation. Merely distributing the nursing protocols did not constitute adequate training. The introduction of the use of nursing protocols to guide nursing assessments, reporting protocols, and documentation of health issues, and to assist in the development of clinically adequate HMPs was a positive step forward and should be continued. However, at the time of the review, no evidence was found in the HMPs or the nursing documentation that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, and/or establish clear and appropriate timeframes for initiating nursing assessments, including 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. Thus, no supporting documentation was found to substantiate that the Facility had actually implemented the nursing protocols. For example, in the case of Individual #89, who was hospitalized three times within the past six months, a “live review” of the medical record was conducted with two members	

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		of the Monitoring Team, several Facility staff including some nurses, members of the Physical Nutritional Management Team (PMNT), and one of the State's Consultants. At the time of the review, the individual was noted to have following medical issues: recurrent episodes of vomiting of an unknown etiology, episodes of lethargy, recurrent episodes of aspiration pneumonia, had a tracheotomy, had episodes of skin irritation, and was enterally nourished via G-Tube. In addition, the Physical Nutritional Management Team was following this individual. Listed below are some of the significant problems found in the nurses' documentation prior to Individual #89 being hospitalization on 1/31/12: ▪ No regular nursing assessments were conducted to address her respiratory status; ▪ No regular nursing assessments were conducted regarding skin integrity; ▪ No specific descriptions and measurements of reddened areas to her skin were included in the documentation; ▪ No consistent skin assessments were conducted to determine if reddened areas were resolving; ▪ The nurses' notes did not indicate exactly when the vomiting episodes occurred to identify any trends of patterns; ▪ No assessments were conducted for variations in oxygen saturations or vital signs; ▪ No documentation was found regarding her activities during the day and her tolerance for activities; ▪ No regular assessments were documented regarding her mental status; ▪ No documentation was found assessing her tolerance for her G-tube feedings; ▪ There was no documentation of assessments of the site of the G-tube for skin break down or infection; ▪ No indication was provided regarding whether she was completely bed-bound or out of bed in various positions during the day; ▪ No assessment was provided of daily urine output; ▪ Due to the lack of consistent nursing assessments conducted, there was no established baseline clinical indicators, such as oxygen saturations, or vital signs; ▪ There was no documentation indicating that the physician, and the PNMT was notified for changes in her health status, vital signs, and oxygen saturations; ▪ The PNMT's documentation did not clearly indicate what assessments were conducted, and what interventions were implemented; ▪ Nursing was unfamiliar regarding where to find the documentation from the PMNT; ▪ Due to the lack of appropriate nursing documentation found in the progress notes, there was no way to determine exactly what health problems nursing staff were assessing and monitoring; ▪ There was a significant lack of follow-up for problems that were noted in the	

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		nursing documentation; ▪ Gaps in documentation were noted for over 12 hours indicating that the individual was not being assessed by nursing; ▪ Significant inconsistencies were found between the intervention contained in the PNMP and the nursing Health Management Plan addressing aspiration; and ▪ No system was in place to ensure that when there was a lack of progress noted regarding a health issues, nurses were adequately reviewing and updating HMPs. This case was an obvious example of the critical need for nursing to develop and implement nursing protocols to guide the needed clinical nursing assessments and the associated nursing documentation. Although at the time of the review, the Facility had 17 Statewide nursing protocols that they reported had been implemented, the Monitoring Team's onsite review of this individual's records, as well as the additional records reviewed regarding changes in status that resulted in individuals being hospitalized, as discussed with regard to Section M.1, found that nursing protocols had clearly not been implemented. Of the significant medical problems listed above for Individual #89, nursing staff had addressed none of them adequately. Consequently, the inadequate care nursing staff provided in relation to nursing assessments and reassessments, nursing follow-up, recognition of changes in status, timely notification of the practitioner and PNMT of status changes, and the development and implementation of clinically adequate nursing Health Management Plans continued to place the individuals residing at LBSSLC at significant risk of harm. Based on the consistent problematic issues found regarding the nursing assessments, Health Management Plans, and the overall nursing care and nursing documentation, it was clear a significant lack of understanding continued to exist regarding the importance of nursing protocols at LBSSLC. This was especially concerning based on the consistent problematic issues the Monitoring Team found regarding individuals with high-risk health indicators, and changes in status warranting repeated hospital admissions. Due to the lack of the actual implementation of appropriate nursing protocols, no structured system was in place guiding nursing practice and documentation to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data was established to quickly recognize changes in health status; ▪ 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 accurately reflected quality standards by	

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		which to measure the Facility's nursing care, and documentation. Although the initial nursing protocols had been introduced to the Facility in November 2011, no evidence was found in the nursing documentation that indicated that they were being used. From the findings from this review and the previous reviews, LBSSLC was continuing to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in compliance with this requirement, which was consistent 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 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.	In the Facility's Self-Assessment, LBSSLC indicated that since the systems addressing this requirement were in the developmental stages, no data were available addressing the following activities to evaluate compliance: ▪ Review of risk assessment to determine if all required nursing assessments and Aspiration Pneumonia/Enteral Nutrition (APEN) evaluations are used in their development; and ▪ Review of Risk Plans to determine implementation within specified timeframes. In addition, the Facility reviewed its data from November 2011 through January 2012, and found that two out of 221 (1%) individuals had an integrated care plan. However, it was unclear to the Monitoring Team why the Facility was monitoring for integrated care plans rather than nursing Health Management Plans addressing the health risk indicators. No formal determination had been made that the Facility had adopted the use of an integrated care plan. Unfortunately, since no monitoring had been conducted of the existing system of Health Management Plans, the Nursing Department had not appropriately focused its efforts on addressing this current problematic system. As reported above with regard to Section M.3, the Monitoring Team found that of 22 individuals, who the Facility identified as being at high risk for specific health indicators, only seven (32%) were found to have an HMP addressing the specific health risk. Moreover, of these seven HMPs, none (0%) were found to be adequate. The Facility's Self Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance as not all individuals have an integrated care plan." Although the Facility's finding of noncompliance was consistent with the Monitoring Team's finding, the reasons for the Monitoring Team's finding of noncompliance, as detailed below, were not in alignment with Facility's stated rationale. This was particularly troubling, because it suggested that the Nursing Department was not appropriately focusing its attention and efforts, and consequently, not making progress, in basic clinical priority areas, such assessing and documenting clinical indicators of risk. In addition, the Provision Action Information report for Section M.5 indicated the	Noncompliance

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		following: ▪ Regarding a positive step forward, in February 2012, the Case Manager Supervisor was assigned to the Risk Workgroup. This group was established to address issues related to the At-Risk process. Since this position was assigned oversight of the RN Case Managers, who were responsible for the development of HMPs and completion of the Comprehensive Nursing Assessments, inclusion of this staff member in the Risk Workgroup should ultimately result in increased attention to these critical nursing areas. ▪ In December 2011, and January 2012, an Action Plan was developed addressing this requirement of the Settlement Agreement. Although the Action Plan found in the Presentation Book for Section M.5 was appropriately focused on improving the quality of the nursing assessments, the documentation contained in the Action Plan indicated that none of the action steps had been initiated. The Facility had implemented a number of steps in its efforts to move forward regarding this requirement, such as the reassignment of the Section I Lead from the Medical Director to the Assistant Director of Programs, and establishing a Risk Workgroup to review and address issues related to the Facility's At-Risk systems (as is discussed in detail with regard to Section I.1). However, the Monitoring Team found that the Facility had made little progress addressing this requirement, and a significant amount of work was yet to be done to address the requirements of the Settlement Agreement regarding at-risk individuals. In addition, discussions with the State's Consultants indicated that the State was considering a number of changes regarding the current At-Risk process that could alter some of procedures regarding the process at LBSSLC. From discussions with the CNE, the Facility continued to use the Quarterly/Annual Comprehensive Nursing Assessment form to address the at-risk individuals. However, consistent with the findings from past reviews, the findings from the Monitoring Team noted below indicated that the quarterly and annual Comprehensive Nursing Assessments reviewed did not adequately address the risk issues. At the time of the review, essentially no progress was noted regarding the nursing assessments for risk indicators. Although the State had made modifications to the Summary Section of the Comprehensive Nursing Assessment form to include a section for health risks, the modification made little impact regarding the quality of the documentation addressing risk indicators. In fact, a number of the summaries the Monitoring Team reviewed appeared not to be the updated version of the Comprehensive Nursing Assessment form. However, consistent with previous findings, regardless of the format of the form, the Comprehensive Nursing Assessments were inadequate, and not representative of a focused assessment addressing health risk indicators.	

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		A review of records for 22 individuals determined to be at risk (i.e., Individual #116, Individual #56, Individual #130, Individual #45, Individual #154, Individual #38, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #264, Individual #306, Individual #86, Individual #13, Individual #304, and Individual #276), found that none (0%) had adequate nursing risk assessments due to: ▪ The lack of adequate assessments of the specific high-risk health indicators; ▪ The lack of an adequate analysis of the high-risk health indicators in the Summary Section; and ▪ The lack of a specific procedure in place defining the process regarding nursing assessments for health risk indicators. In addition, a review of these 22 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for providing the assessment information and proposed rating on the Integrated Risk Rating forms. Although some improvement was noted in some of the categories on the Risk Rating forms, the review found that only three (14%) consistently contained specific clinical information to enable the IDTs to adequately evaluate and designate risk levels. For the remaining individuals, there was a lack of clinical information regarding some of the health risks indicators found on the Integrated Risk Ratings forms (i.e., Individual #56, Individual #130, Individual #45, Individual #154, Individual #111, Individual #270, Individual #281, Individual #174, Individual #245, Individual #80, Individual #23, Individual #120, Individual #322, Individual #184, Individual #306, Individual #86, Individual #13, Individual #304, and Individual #276) due to the following problematic issues: ▪ No Integrated Risk Rating forms were included in the requested documents for six individuals (i.e., Individual #13, Individual #304, Individual #306, Individual #45, Individual #281, and Individual #174). As a result, it was unclear if nursing assessments were needed or not. ▪ An Integrated Risk Rating form for Individual #184 had been completed a year prior to the ISP without being reviewed, and updated. Consequently, it was not clear if further nursing assessments were needed based on the person's current status. ▪ For the remaining individuals, there was a lack of specific data, such as how many seizures the individual had in the past year compared to previous years; or information addressing the regular bowel medication regimens, the frequency of needed bowel pro re nada (PRN, or "as needed) medications, and additional factors such as medications, fluid intake, and positioning affecting the risk of constipation supporting the risk rating; lack of consistent results of cultures and sensitivities for urinary tract infections to evaluate hygiene practices by staff;	

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		lack of specific dates and locations of past fall and/or fractures; and lack of consistent information, such as dates, locations, and organisms of infections; In addition, a review of the 22 records for individuals determined to be at risk, there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, no supporting documentation verified that the action steps contained in the plan had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the 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 15 of the cases (68%). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. From previous discussions with the State Office staff and consultants, the State was in the process of reviewing the At-Risk procedures, and redefining the "assessment" requirements noted in the At-Risk Individuals policy in an effort to clarify the expectations regarding risk indicators and the associated assessments. However, at the time of the review, no formal clarifications had been made to the At-Risk policy. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. At the time of the review, LBSSLC indicated that they were not in compliance with this requirement of the Settlement Agreement, which was consistent with the findings of the Monitoring Team.	

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M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Based on a review of the Facility's Self-Assessment, the Monitoring Team found the following: ▪ The Facility reported that a review of their database to determine nurse competency in medication administration indicated that from October 2011 through January 2012, 65 out of 65 (100%) were competent regarding medication administration. However, the specific criteria used to determine compliance were not provided. ▪ From a review of the data from the Medication Observation Tools used to determine nurse competency regarding the utilization of the Physical Nutritional Management Plans (PNMPs) prior to medication administration, the Facility reported that from October 2011 through January 2012, eight out of 10 (80%) nurses were found to be competent. However, while the Monitoring Team was on site, observations continued to show a number of problems with regard to nurses' implementation of the PNMPs during medication administration. The Facility's monitoring did not appear to have identified these same serious issues. In addition, no evidence was presented that the nurse monitors had received any training regarding the PNMPs in order to monitor this area accurately. This called into question their clinical competence related to the implementation of PNMPs, and made the data questionable. In addition, no information was provided to show that inter-rater reliability had been established for the monitoring tool to ensure data reliability. Given the consistent problematic findings from past reviews as well as the current review regarding nursing knowledge and implementation of PNMPs during medication administration, as well as the discrepancies found between nursing HMPs and PNMPs (as discussed with regard to Section M.1), which indicated that nurses did not review the PNMPs, the Facility's reported compliance score of 80% seemed very unlikely. Also, as noted previously regarding the Facility's data, no specific criteria were provided regarding how nurses' competency was determined. In addition, no explanation was provided regarding what the single, composite compliance score represented. ▪ The Facility's review of data from the Medication Safety and Systems Committee regarding the effectiveness of a plan implemented to reduce the number of returned medications to the pharmacy found that from October through December 2011, there was an 81% reduction of returned medications for the piloted homes, and a 25% reduction for the Facility. Although discussions with the CNE and the Clinical Pharmacist clarified the details of this action as noted below, the Self-Assessment lacked details such as explaining what the pilot consisted of, when and where it was implemented, and what specific data supported the percentages reported. The lack of specific information found in the Self-Assessment addressing this issue actually understated what was a very	Noncompliance

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		positive step forward in addressing this provision. ▪ The Facility's review of data from the Medication Safety and Systems Committee regarding the effectiveness of a plan implemented to reduce/eliminate unsigned medications on the Medication Administration Records (MARs) found that from October through December 2011, unsigned medications were reduced by 61.4%. However, again the Facility's Self-Assessment lacked specific information, and data supporting this positive finding. Regarding the Facility's compliance rating, the Self-Assessment stated: "based on this self-assessment, this provision is not in substantial compliance as all nurses are not competent in utilization of PNMP prior to medication administration and continued efforts to improve medication administration are needed." Although very little information was provided in the Facility's Self-Assessment, interviews with the CNE and Clinical Pharmacist, and review of the Provision Action Information report, and the minutes of the Medication Safety and Systems Committee regarding the Facility's activities related to the overall medication administration system identified that that since the last review, the Facility had initiated the following steps: ▪ In November 2011, in an attempt to decrease the number of medication variances, and the number of unexplained medications returned to the pharmacy, the Facility initiated a pilot program on 513 S. Cedar. The program consisted of separating the seven-day refilled medications by shifts to reduce the number of medications that were contained in one medication drawer. Due to the success of this pilot, this system was expanded to other residences, and were expected to be initiated Facility-wide. The Facility reported that returned medications dropped from 959 in December 2011, to 730 in January 2012, with a slight increase noted in February 2012 of 750. Both the CNE and Clinical Pharmacist were hopeful that once this new system was implemented Facility-wide, the rates of returned medications would continue to significantly decrease. This was a very positive system change, although indicative of the number of medication dosages that nurses were not appropriately administering. ▪ In addition, due to the large number of MAR blanks left unsigned by the nurses administering medications, the Facility initiated another positive step by having the RN Unit Managers conduct weekly MAR monitoring. The Facility reported that from December 2011 to January 2012, the number of MAR blanks had decreased by 219 to 21; a 91% reduction in unsigned MARs. Clearly, the regularly monitoring of the MARs had a positive outcome, and should be continued. ▪ In October 2011, a Root Cause Analysis (RCA) Committee was established in response to three incidents of medications being given to the wrong individuals	

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		during one month. ▪ Also, in October 2011, the members of the Medication Safety and Systems Committee decided to review every variance involving medications given to the wrong individual regarding the cause, and contributing factors, and to collaborate with the RCA Committee regarding recommendations. ▪ The minutes of the Medication Safety and Systems Committee, and the Root Cause Analysis Committee indicated that to decrease medication variances related to medications being given to the wrong individual, the Facility was in the process of implementing a pilot project at the 521 residence that included training of the direct support professionals regarding their responsibilities during medication administration in assisting the individuals and the nurse. At the time of the review, the Facility was in the process of developing laminated identification cards with each individual's picture on them to hand to the nurse for comparison to the individuals' pictures contained in the medication rooms. This was designed to be an additional safety step to ensure the right individual was receiving the right medications. This was a very creative process the Facility developed. It should produce some positive outcomes regarding increased communication between nursing staff and the direct support professionals, and possibly decrease the occurrences of these types of medication variances. ▪ Related to the above process, the Facility developed a Residential Coordinator Medication Pass Monitoring Form. Residential Coordinators were to complete these twice per month while observing the direct support professionals during medication administration. Two monitoring forms were developed, including one tailored for the medication administration for individuals residing at Sparrow and Quail who receive their medications in their rooms, and another for the other campus-wide residences where individuals received their medications in the Medication Rooms. Overall, based on a review of the tools, the items being monitored included: was privacy provided for the medication pass; did staff verbally identify the individual to the nurse passing medications; did staff take one person at a time to the Medication Room; did staff encourage the individual to wash their hands; did the nurse verbally identify the individual to the direct support professional; did the nurse check the picture on the MAR before giving the medication; and did the nurse sanitize his/her hands between individuals. Although the minutes of the Review of Residential Medication Pass Observations meeting minutes, dated 2/6/12, and 3/8/12, indicated that the monitoring had been implemented, the Monitoring Team could not accurately interpret the findings. Using a standardized format for the presentation of data that included the sample size, the timeframe the data represented, established inter-rater reliability for the tools, and the percentage of compliance by item would have	

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		facilitated the interpretation of the data. In addition, the overall format of the meeting minutes lacked specific content in order to determine precisely what issues were discussed, and what type of analysis was conducted on the monitoring data. Also, it was not clear from the minutes when specific actions were actually implemented, and how effective they were in addressing problematic issues. Including these components in the minutes would significantly enhance the content, close the loop on issues that actually have been resolved, and indicate what issues continue to need interventions. However, there appeared to significant potential regarding this newly implemented identification and monitoring system in generating a number of positive outcomes. ▪ The Facility had developed a method to ensure that the individuals' allergies were included on all Physician Order Sheets. ▪ Although none had been yet reported, an interview with the Clinical Pharmacist indicated that the Facility was now including any pharmacy and medical variances in the Facility's data. Although the above steps included some very promising, and inventive interventions, LBSSLC continued to have some significant problematic issues regarding its overall medication administration system. From review of the Medication Safety and Systems Committee meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, the Facility's medication variance data, Medication Administration Observation data, the Monitoring Team's observations while on site, and discussions with Nursing Department staff, the following were some of the problematic issues identified: ▪ The Facility reported that the percentages of compliance from the Medication Administration Observations conducted consistently were found to be between 95% and 100%. However, based on the Facility's data indicating that 5,733 unexplained medications were returned to the pharmacy from September 2011 through February 2012; the problems identified regarding the nurse not appropriately identifying the individual, and privacy not being provided as identified through the raw audits from the Residential Coordinator monitoring tools; the significant number of MAR blanks reported by the Facility from September 2011 through February 2012; the high rates of compliance found from the enteral monitoring audits that was not in alignment with the Monitoring Team's observations while on site; and the on-going discrepancies found between the Monitoring Team's observations of medication administration, compared to the Nurse Educator's observations regarding compliance, the accuracy of the Medication Administration Observations was markedly questionable. However, there was no indication that nursing was analyzing these obvious discrepancies in data.	

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		▪ A review of the minutes of the Medication Safety and Systems Committee, dated 2/15/12, indicated that the Assistant Nurse Educator was now conducting all of the Medication Administration Observations for LVNs and RNs. Although limiting the number of nurse auditors for this area was a positive step, it was unclear from the minutes why the Nurse Educator was continuing to establish inter-rater reliability for the Medication Administration Observation tool with a QA Nurse, rather than the Assistant Nurse Educator, who was conducting all the monitoring observations. As noted in previous reports, there continued to be a lack of understanding regarding the process, and purpose of establishing inter-rater reliability. ▪ In addition, from discussions with the CNE and QA Nurses regarding the determination of passing or failing a medication administration observation, the Facility had been calculating a single compliance score from the items contained on the Medication Administration Observation monitoring tool. However, since the items on the tool were not weighted according to priority and safety, single compliance percentages could reflect high compliance scores, yet the nurses observed could have inadequately performed a critical procedure. For example, a nurse could have drawn an exceedingly wrong dosage of insulin, but with the current scoring procedure, this critical error would not have been accurately reflected in the single compliance score for that particular medication observation. In fact, using the Facility's current scoring system for compliance, this observation would have resulted in a score over 95%. ▪ Although actions had been recently implemented, at the time of the review, the Facility continued to have problems regarding a number of unexplained medications that were being returned to the Pharmacy each month, indicating a number of dosages were not being given as ordered. ▪ The lack of consistent nurses assigned to specific residences due to staffing issues, such as vacant nursing positions or leaves of absence, had been identified repeatedly in meeting minutes, as well as in previous interviews with the CNE. However, there was no indication that a plan or procedure was developed and implemented to address these situations that continued to occur. ▪ Although the Facility was spending much time reconciling the massive number of unexplained returned medications and MAR blanks each month, the number of actual medication variances suggested that LBSSLC continued to have a significant problem regarding the under-reporting of medication variances. A review of the medication variances reported by the Facility indicated the following: ▪ September - 388 total variances, and 852 unexplained returned medication; ▪ October - 252 total variances, and 1160 unexplained returned medication; ▪ November – 261 total variances, and 1282 unexplained returned medication;	

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		▪ December - 257 total variances, and 959 unexplained returned medication; ▪ January 2012 - 34 total variances, and 730 unexplained returned medication; and ▪ February - 52 total variances, and 750 unexplained returned medication. Based on observations of medication administration at 504 E. Mesquite Drive, the following problematic issues were found. Specifically, the nurse did not: ▪ Follow the PNMP mealtime plan when administering oral medications. The nurse was standing while trying to give Individual #195 her medications. This made her lift her head and chin into a position that was not consistent with the PNMP, and placed the individual at greater risk for aspiration; ▪ Evaluate lung sounds in response to a coughing episode the individual experienced during medication administration. The nurse reported that the coughing was due to the taste of the medication, but did not recognize the need to conduct an assessment in response to a trigger for aspiration no matter what the cause; ▪ Did not attempt to allow the medications to flow through the G-Tube by gravity before pushing them in with the syringe, although the nurse did recognize this error during the process; ▪ Visually check the PNMP to ensure individuals were in the proper positioning prior to and after medication administration. Although the nurse was able to articulate the correct position without visually reviewing the PNMP, any changes made in the plan would be missed. Moreover, the Nurse Educator conducting the Medication Administration Observation did not review the PNMPs to verify that the nurse knew the PNMP, and was initiating it correctly regarding positioning prior to and after medication administration, and/or other individualized strategies; ▪ Direct the direct support professionals regarding the position to maintain after the medication was administered; ▪ Provide education to the individuals regarding the medications that they were receiving; ▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications. As noted previously with regard to Section M.3, the Facility reported that in February 2012, the RN Case Managers conducted some initial monitoring for individuals receiving enteral feedings. As reported in the Facility's Self-Assessment, the findings of this monitoring noted that of 39 individuals, 32 were properly positioned, nutrition orders were congruent with treatment records, pumps and poles were cleaned, and that direct support professionals and nurses were familiar with the rationale for receiving enteral	

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		feedings and the dangers of not following the Physical Nutritional Management Plans. However, as noted previously, no information was provided regarding if and how the RN Case Managers were trained regarding the monitoring criteria, if inter-rater reliability was established for the tool, and if the Physical Nutritional Management Team was involved in the process. In addition, without competency-based training being provided to the nurses and the nurse auditors regarding the PNMPs for each individual the accuracy of the findings was questionable, and did not comport with the Monitoring Team's observations noted above or the findings related to Section M.1. Based on the consistent problematic issues observed during medication administration at LBSSLC, 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 all 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 a number of problematic issues continued to be noted regarding the medication administration systems at LBSSLC, the Facility clearly had taken steps to thoroughly review some of the problematic elements of the medication administration system, and recently had implemented some promising systems to address these areas. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets, including the Medication Administration Observations. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. At the time of the review, the Facility indicated that it was not in compliance with the requirements of this provision. This was consistent with the findings of the Monitoring Team.	

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. As LBSSLC's policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of the new Case Manager Supervisor position. (Section M.1)
3. In reviewing and monitoring the quality of nursing documentation according to standards of practice for nursing, the use of nursing protocols should be integrated into the instructions of the Health Monitoring Tools. (Section M.1)
4. The Nursing Department in conjunction with the QA Nurses should develop and implement formal reports addressing the analyses of the nursing data generated from the Health Monitoring Tools. (Section M.1)
5. The Facility, in conjunction with the State, should ensure that each monitoring tool has appropriate instructions identifying the specific criteria that constitute compliance with each item being monitored. (Section M.1)
6. 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)
7. The presentation of 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 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)
7. The Facility should continue to implement and expand the use of nursing protocols to guide nursing practices in conjunction with the adequate competency-based nursing skills training. (Section M.1)
8. The Facility should consider automating the data regarding the timely filing of documents in the active records or monitoring a percentage of documents monthly, so that the findings addressing these data are more available, and less time intensive to aggregate. (Section M.1)
9. The Facility should develop and implement a system to ensure the adequacy and implementation of Health Management Plans addressing infectious and communicable diseases. (Section M.1)
10. The Facility should continue to focus and expand its efforts on the implementation of the clinical Real Time auditing tool assessing the clinical practices and treatments of infectious and communicable diseases. This should include 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)
11. The Facility should develop a list of individuals who have had and those who still need their immunizations researched in order to render them current. (Section M.1)
12. The Facility should continue to conduct and expand its analyses of the Infection Control data, such as any associated trends regarding the organisms found from the cultures, the units that experienced the most frequent occurrences, comparisons of quarterly data for the current year to the same quarter in previous year, and overall Facility trends in infections. In addition, integrating the findings of the Real Time Infection audits with the current IC data should produce additional actions steps to be implemented in addressing some of the problematic trends identified. (Section M.1)
13. 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 Infection Control Program. (Section M.1)
14. The Facility should give consideration to implementing a system where staff are required to actually go to the location of the closest Automated External Defibrillator in order to demonstrate knowledge regarding where the closest AED is kept, as would be the case in an actual emergency. (Section M.1)
15. The Facility should review all data related to its emergency systems, and analyze the findings from the Mock Drills to ensure that any training provided translates into improved practices in the residences. In addition, trends from the actual codes should be identified and analyzed, so

that appropriate corrective actions can be timely implemented. (Section M.1)

16. The Facility should implement a system to ensure that the emergency equipment is being checked daily as required. (Section M.1)
17. The Facility should provide appropriate competency-based training from a competent source to ensure that the Comprehensive 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)
18. For individuals transitioning to the community, nursing staff should provide a clear and comprehensive analysis summarizing the individual's health/mental health issues since they have been at the Facility, as well as their current status. This information should be available from the summaries from the Quarterly/Annual Comprehensive Nursing Assessments. In addition, Nursing Care plans addressing all health issues, including individual-specific nursing interventions the individual needs should be provided to the receiving staff. Also, a summary of the goals and progress of any nursing programs should be included in the documentation for transition/discharge. (Section M.2)
19. Health Management Plans should be in alignment with standard nursing protocols and 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 be reviewed and by whom. (Section M.3)
20. The use of nursing protocols should be incorporated into competency-based training regarding Health Management Plans, and used to measure the participants' competency. (Section M.3)
21. The Facility should actively and aggressively begin to develop and implement appropriate Health Management Plans for all individuals at LBSSLC based on priority, and risk. (Section M.3)
22. 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)
23. It is critical that the Facility ensures the use of the current nursing protocols. In addition, 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 regularly monitoring the Medication Administration Records. (Section M.6)
26. The Review of Residential Medication Pass Observations meeting minutes should include information regarding when specific actions were actually implemented, and how effective they were in addressing the identified problematic issues. Including these components in the minutes would significantly enhance the content, close the loop on issues that actually have been resolved, and indicate what issues continue to need interventions. (Section M.6)
27. The Facility should develop and implement a system of reviewing all data addressing the medication administration system including data from the Residential Coordinator monitoring tools, the number of MAR blanks reported by the Unit Managers, data generated from the enteral monitoring audits, and data from the Medication Administration Observations to identify and analyze any discrepancies found between the data sets. (Section M.6)
28. Given that the items on the tool were not weighted according to priority and safety, the Facility should reassess how it determines compliance scores regarding Medication Administration Observations. (Section M.6)
29. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a Physical and Nutritional Management Plan, they are provided competency-based training regarding these plans. (Section M.6)
30. The Facility should continue critically reviewing all aspects of the medication administration system in order to accurately identify problematic

areas, and implement actions aimed at long-term resolutions. (Section M.6)

31. The Facility also should develop and implement strategies to increase the reliability of the medication variance data. (Section M.6)
32. 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)
33. 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: o **Review of Following Documents**: o Policies, procedures and/or other documents addressing the provision of pharmacy services; o Any pharmacy surveys completed within the last year, including plans of correction and/or internal auditing procedures and reports related to pharmacy services; o Since the Monitoring Team's last visit, all Drug Utilization Evaluation (DUE) reports completed (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results); o Any follow-up studies completed for any prior DUE reports; o Since the Monitoring Team's last review, minutes of Pharmacy and Therapeutics Committee meetings and any attachments; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Since the Monitoring Team's last review, minutes of any committee addressing medication error/variance; o Since the Monitoring Team's last review, minutes of the committee addressing seizures with any attachments; o DUE calendar for next 12 months (specify if fiscal year or calendar year); o The most recent Quarterly Drug Regimen Reviews (QDRRs) for two individuals per residence that have been completed with physician signatures and dates: Individual #154, dated 1/10/12; Individual #264, dated 12/1/11; Individual #70, dated 1/3/12; Individual #250, dated 1/3/12; Individual #136, dated 1/31/12; Individual #7, dated 1/9/12; Individual #222, dated 2/8/12; Individual #193, dated 11/30/11; Individual #35, dated 2/6/12; Individual #34, dated 1/9/12; Individual #147, dated 2/6/12; Individual #260, dated 12/28/11; Individual #179, dated 11/30/11; Individual #238, dated 11/30/11; Individual #176, dated 1/31/12; Individual #86, dated 12/2/11; Individual #308, dated 1/2/12; Individual #124, dated 1/10/12; Individual #60, dated 12/1/11; Individual #167, dated 1/31/12; Individual #120, dated 12/28/11; Individual #191, dated 1/31/12; Individual #280, dated 1/2/12; Individual #112, dated 12/1/11; Individual #271, dated 11/30/11; Individual #132, dated 2/6/12; Individual #25, dated 12/1/11; Individual #58, dated 2/8/12; Individual #55, dated 2/6/12; and Individual #316, dated 12/2/11; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders; for 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement: Individual #160, dated 10/5/11; Individual #100, dated 10/5/11; Individual #34, dated 10/11/11; Individual #99, dated 11/10/11; Individual #92, dated 10/11/11; Individual #322, dated 10/11/11; Individual #94, dated 10/11/11; Individual #113, dated 10/5/11; Individual #191, dated 11/2/11; and Individual #310, dated 10/11/11; o Since the Monitoring Team's last visit, all "single patient intervention reports" in WORx

	system; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with "single patient intervention reports;" o For the past six months, any adverse drug reaction (ADR) reports completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors variances per month for prior 12 months by error type, nurse, residence, shift, unit, individual, category of severity, and error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o The last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Since the Monitoring Team's last review, any communication between the Pharmacy and Nursing Departments concerning medication errors/variance (e.g., emails, memos, etc.); o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history of individuals with Jejunostomy Tube (J-tube) or Gastrostomy/ Jejunostomy Tube (G/J-tubes) (not G-tubes); o A schedule of when Quarterly Drug Regimen Reviews (QDRRs) are conducted by home/unit; o Polypharmacy risk assessment forms for past six months for five individuals most recently rated as being at high risk for polypharmacy, and five individuals rates as being at medium risk for polypharmacy; o All documentation for each emergency chemical restraint, including the restraint checklist for: Individual #57 on 12/30/11 1610hr, 1/1/12 1950hr, 1/3/12 0848hr, and 1/4/12 1325hr; Individual #213 on 1/30/12 0831hr; Individual #242 on 9/13/11 0830hr, and 9/13/11 1603hr; Individual #288 on 10/2/11 2110hr, 12/5/11 1640hr, and 1/7/12 1638hr; and Individual #51 on 10/2/11 0200hr, and 10/2/11 0905hr; o Any trend analysis of chemical restraint use (e.g., graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o Dates of last two completed QDRRs for all individuals; o New order review of drug-drug interaction for 10 individuals; o New order review of allergic drug reaction for one individual; o New order review of drug dosage below or exceeding normally prescribed dosage regimen for five individuals; o New order review of lab monitoring for five individuals;

	o "Notes extracts" definition of restricted drug; o Procedure for PCP confirmation and signature for drug interaction alert; o Restraint checklist page for pharmacy and psychiatry chemical restraint review for Individual #57; o Complete restraint checklist forms (i.e., face-to-face, debriefing, pharmacy and psychiatry sections), for Individual #242; o Drug utilization evaluation for fiscal year 2012-2013; o New order review of significant side effect notification for five individuals; o Agenda and handouts of 3/19/12 Medication Safety and Systems Committee; o Residential medication pass observations meeting minutes, dated 2/6/12, and 3/8/12; o Pharmacy State monitoring tool data; o Agenda and handouts of 3/20/12 Pharmacy and Therapeutics Committee Meeting; and o Presentation Book for Section N. o **Interviews with**: o Billy Bob Beck, Director of Pharmacy; o John Todd, RPh, Clinical Pharmacist; and o Robert Colvard, Registered Pharmacist. o **Observations of**: o P&T Committee Meeting, on 3/20/12.
	Facility Self-Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating using the information cited in the section on results. Also provided was a "Provision Action Information" document that had been recently updated. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. Results and self-ratings were provided for each subsection of Section N. With regard to Section N.1, a QA/QI process had been developed to review new orders at LBSSLC. The clinical pharmacist reviewed 100% of the drug-drug interactions and 100% of the orders needing lab monitoring. Allergies, drug dosage ranges, and significant side effects also were reviewed. However, for some reason, the Facility's findings with regard to these last three components of Section N.1 were not included in the Facility's Self-Assessment document. In addition, there appeared to be a gap in the software system for reviewing medications appropriate for J-tube administration. There were also other inconsistencies found in the physician orders in reference to enteral feeding tubes, but the Facility's Self-Assessment did not identify this issue. For Section N.2, the Facility reviewed each of the most recent quarterly drug regimen reviews for monitoring of laboratory results to ensure they were ordered in a timely manner, and orders took into consideration relevant lab values. The Facility tracked timeliness of QDRR completion across campus, and

	determined it was compliant at a rate of 100% for all buildings. For Section N.3, the Facility reportedly had conducted a review of each of the elements of this subsection. However, the Facility's data was not spelled out in detail for each of the specific indicators. Although this might be sufficient if all indicators are scored at 100%, it would not be helpful to the Facility if there were variation in the scores. The Facility's self-assessment process should be designed to allow the Facility to quickly identify where problems exist, so that they can be rectified. The Facility provided an important pharmacy review for chemical restraints. The Monitoring Team agreed with the Facility's self-assessment that issues continued to exist with the chemical restraint review process. For Section N.4, the practitioners appeared to agree with nearly all recommendations made by the Pharmacy Department. Internally, the pharmacy monitored completion and accuracy of the QDRR, but did not assess timeliness for the practitioners' response. The Facility's result showed 100% compliance with each element of the QDRR. The Monitoring Team found 100% compliance with the content of the QDRRs reviewed. However, the PCPs appeared to process the QDRRs beyond 14 business days. Similarly for Section N.5, although the Facility mentioned the need to ensure that prescribing practitioners reviewed MOSES and DISCUSS evaluations, this was not factored into its compliance rating. As a result, the Facility's finding of substantial compliance was different from the Monitoring Team's finding of noncompliance. For Section N.6, the policy and procedure remained in place. The clinical pharmacist continued to train the Nursing Department concerning observation of adverse drug reactions. Based on the Facility's data, only 48% had been trained. For Section N.7, the drug utilization evaluation program followed the calendar with two completed DUEs with reporting through the P&T Committee. For Section N.8, the pharmacy had continued to methodically review the causes for medication variances and returned medication. Several different projects had been initiated with nursing collaboration, and there was improvement in medication variances. The pharmacy scored a sample of medication errors and found no discrepancies with the nursing scores. This was different from the Monitoring Team's finding that two out of 13 medication errors were not scored according to current policy. The Facility recognized, though, that much work was needed to identify and implement corrective action plans related to medication variances. The Facility determined it was in substantial compliance with Sections N.1, N.2, N.4, N.5, and N.7. However, as noted above, there were irregularities noted with regard to N.5. The Monitoring Team found the Facility to be in substantial compliance with Sections N.1, N.2, N.4, and N.7.
	Summary of Monitor's Assessment: The Pharmacy Department continued to make progress towards achieving compliance with this section. Based on the review of submitted documents, the pharmacy

	processed new orders with attention to drug-to-drug interactions, side effects, allergies, lab results and monitoring, and dosage adjustments. However, medication use with individuals with J-tubes appeared to be an area needing further review. The pharmacy was not receiving all the chemical restraint forms for review and comment. The comment section had improved, but there was need for additional information. The QDRRs were of high quality and were inclusive of many of the topics listed in Section N. The drug utilization evaluations were completed in a timely manner. Adverse drug reaction training needed to continue. The pharmacy had made several in-roads into reducing medication variances on campus. Significant challenges remained, but the department had collaborated with nursing to continue to improve the safety of the system.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication 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 the Pharmacy Director, one clinical pharmacist, two additional registered pharmacists, and two pharmacy technicians. A list of those currently certified in CPR was submitted, dated 2/7/12. There was no one on the list from the Pharmacy Department. The Monitoring Team could not determine if the list did not include those certified in CPR from the Pharmacy Department, or whether no one in the department was certified. The Facility is encouraged to ensure all personnel assigned clinical responsibilities are certified in CPR. A sample of new prescriptions was reviewed. This included 10 new prescriptions for which there were drug-drug interactions. It also included one new prescription for which the active record indicated an allergy (the Monitoring Team requested five new prescriptions in which an allergy generated a patient intervention, but the Facility could only identify one). Five new prescriptions in which there was a potential need for a drug dosage adjustment were included in the review. The Monitoring Team also requested five new prescriptions in which lab was reviewed/monitored. For each of these the warning box indicated the labs that needed to be considered (e.g., renal function, hepatic profile, etc.). Additionally, five new prescriptions involving significant or serious side effects were submitted for review. The following summarize the results: ▪ For 10 of 10 new prescriptions (100%), a review was completed of drug-drug interactions with the current drug regimen prescribed. ▪ For each, the information flagged in the software system was reflected in the patient intervention form.	Substantial Compliance

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		▪ For each, the PCP signed the "single patient intervention report." ▪ For one of one new prescription in which an allergy in the active record was documented (100%), allergies were reviewed ▪ For this potential allergy, the PCP signed the "single patient intervention report." ▪ For five of five new prescriptions (100%), significant side effects were reviewed. ▪ For all five, a PCP Communication Form was signed and dated by the PCP. This was one step of the Facility's "drug interaction alerts – new order processing." ▪ For each of the five, an adverse effects drug sheet (with bullets of common side effects and separately bullets of serious side effects) was included. ▪ For three of five (60%), current laboratory results and potential need for further testing or review were addressed. For two of these, there were labs attached, but the labs did not reflect the recommended monitored labs identified by the warning on the computer screen. This may have been an oversight in submission of information to the Monitoring Team. ▪ For each of these, the PCP signed the "single patient intervention report." ▪ For five of five (100%), consideration was given to dosage adjustments. ▪ For four of five (80%), the PCP signed the "single patient intervention report." For the unsigned "single patient intervention report," the final report indicated that the pharmacy had contacted the PCP and discussed the concern in the report. The Facility submitted patient interventions from the pharmacy software system WORx. There were 245 patient interventions that required communication with the PCPs from October 3, 2011 through February 1, 2012. For the subcategory of adverse drug reactions (potential drug-drug interactions), there were 36 patient interventions in October 2011, 35 in November 2011, 41 in December 2011, and 48 in January 2012. Under the subcategory of "drug information," there were reviews of lab results, lab monitoring, and medications orders that were discussed with the PCPs. The total patient interventions per month for this lab information was as follows; October 2011 – 13, November 2011 – 25, December 2011- 10, and January 2012 – 12. The pharmacy created an internal monitoring tool for the patient interventions recorded in the WORx system. For the review, 100% of the recorded drug-drug interactions for each month and 100% of laboratory interventions for each month recorded in WORx were reviewed. Each intervention was matched to the PCP communication forms that were reviewed and signed by the PCP. Compliance was then calculated. Based on the Facility's review, for September 2011, there were 25 drug interventions reviewed, and PCP communication forms were reviewed and signed in 100% of these. There were 18 lab interventions recorded in WORx, and each was reviewed and signed by the PCP. According to the Facility, compliance was 100%. Monitoring was similarly completed in October 2011 through January 2012. According to the Facility, compliance was 100% in	

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		each month. There reportedly was documentation of communication and review of information by the PCP in each case. As noted above, the Monitoring Team's more limited review found problems in some cases with the laboratory monitoring, as well as PCP signatures on the intervention forms. The pharmacy provided a summary of the impact of the intervention tracking of new prescription orders in a document entitled: "Intervention tracking – pharmacy services. Fiscal year 2012." From September 2011 through February 2012, the following interventions occurred: drug interactions: 255 drug interactions, 94 laboratory monitoring, one drug allergy, and one dosage range intervention. The total number of interventions was 351.	
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.	An updated document, dated 2/16/12, was submitted which listed the two most recently completed QDRRs for each individual at LBSSLC. Each QDRR was completed at the 90th day from the date of the prior QDRR. Using this list, this was reviewed for the entire campus, and for all 222 individuals, the most recent QDRR was within 90 days of the prior QDRR. QDRRs were scheduled for completion with residences listed for each month, on a rotating schedule to ensure each residence was completed every three months. For each month for which the residence was listed, the prior three months would be reviewed as part of that month's QDRR. For instance, for the QDRRs completed in January, the months reviewed would be the prior three months (October through December). For 2012, each month, QDRRs were to be completed for the individuals living in five residences. A sample of two QDRRs was submitted from each residence, for a total of 30 QDRRs. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 30 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for laboratory data applicable to the individual, such as Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (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). ▪ For 30 QDRRs, all labs (100%) had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. ▪ Not all QDRRs indicated abnormal labs, as most values were therapeutic or within normal limits. However, there were three QDRRs that indicated	Substantial Compliance

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		significant clinical concerns. These should have resulted in a recommendation, but were not (Individual #136, Individual #124, and Individual #191). This resulted in a compliance rate of 27 out of 30 (90%). Although the Facility's previous finding of substantial compliance was not affected, this is an area the Facility should review, and address, as needed to ensure that future compliance findings are not negatively impacted. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. There did not appear to be any overdue lab testing, according to the QDRRs.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	This 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 12 chemical restraints used from 9/13/11 to 1/30/12. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that five individuals had the 12 chemical restraints. Information was not provided on these forms indicating how the maintenance medication, and/or BSP/environmental factors were being reviewed and/or changed in order to reduce the use of chemical restraints, especially for the individuals that had multiple chemical restraint use. For the 12 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. For four chemical restraints, there was no pharmacy or psychiatry section completed. This was confirmed with the Pharmacy Department. The following summarizes the review of the eight chemical restraint documents that were forwarded to pharmacy and psychiatry for completion: ▪ Of the eight chemical restraint forms, four forms (50%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in eight out of the eight chemical restraint forms completed (100%).	Noncompliance

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		▪ Side effects/adverse effects/risks were noted in three of the completed chemical restraint forms (38%). ▪ There were three statements that were considered recommendations. ▪ The pharmacist signed and dated six of eight forms (75%). ▪ The range of time for completion of the forms following the date of the chemical restraint administration was from three to 31 days. 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 eight completed chemical restraint forms, there were eight forms (100%) on which the psychiatry comment section was completed. ▪ For eight of the chemical restraints used (100%), the psychiatrist determined there was clinical justification. ▪ Behaviors leading up to the use of the chemical restraint were described in seven of eight (88%) chemical restraint forms. ▪ Prior steps taken by the staff before administration of the chemical restraint (i.e., identified steps in the BSP that were followed, but were not successful in resolving the problem) were described in five (63%) of the chemical restraint forms. ▪ Side effects were mentioned in three of the reviews (38%). ▪ Effectiveness was documented in eight of the cases (100%). ▪ There were five recommendations documented. ▪ The range of time for completion of the forms following the date of the chemical restraint administration was from one to 16 days. Separately, a graph of the chemical restraint use per month was submitted from January 2010 through January 2012. Peak months of chemical restraint use included March, May, and June of 2011, as well as January 2012. The graph indicated that nine chemical restraints were used in January 2012, although documents submitted for chemical restraints only included five chemical restraints for January 2012. The graph listed three chemical restraints in December 2011, but only two chemical restraint forms were submitted. A third dataset entitled "all chemical restraints LSSLC: report date 8/1/11 – 1/31/12" agreed with the graph information. There were three chemical restraints for Individual #242 (1/23/12 at 2:45 p.m., 1/24/12 9:34 a.m., and 1/24/12 11:40 p.m.) that had not been submitted for review in response to the original request for all chemical restraints in the prior six months. It is recommended the Facility continue to review the various databases for chemical restraints to ensure they are complete, accurate, and the content of information is consistent across the databases. In response to a second request, the Facility submitted the three chemical restraint forms	

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		for Individual #242 (one for 1/23/12, and two for 1/24/12), but none had been routed through the Pharmacy or Psychiatry Departments, and had not been processed. For this time period, the total number of chemical restraints was 15. For seven, the Pharmacy and/or Psychiatry Departments had not completed the chemical restraint checklist form. This was a compliance rate of eight out of 15 (53%). The October 5, 2011 Pharmacy and Therapeutics Committee minutes reviewed the prior fiscal year ending August 2011. For the twelve-month period, there had been 46 chemical restraints for 13 individuals. One individual had accounted for 13 (28%) of the chemical restraints, and a second individual had accounted for eight (17%) of the chemical restraints. The minutes did indicate that: "there was no indication that the restraints were ever utilized as a substitute for long term treatment." However, there was no information how this statement applied to the two individuals that received 45% of the restraints. <u>Polypharmacy</u> Of the 30 QDRRs reviewed, polypharmacy was noted in 20 reviews. ▪ Justification by diagnosis was documented in 20 (100%). ▪ Side effect risk was reviewed in 19 (95%) of those with polypharmacy. ▪ For 19 (95%), the QDRRs identified the document that reviewed justification (effectiveness, risk/benefit, etc.) of the polypharmacy. Polypharmacy also was reviewed at the Pharmacy and Therapeutics Committee. At the 12/14/11 meeting, the psychiatrist reviewed the results of the November 2011 data. Of 122 individuals on psychoactive medications, 16 individuals with greater than one year of residence at the Facility had stable polypharmacy prescribed (this included those with a long history of medication regimen evaluation who were currently stable and for whom no drug changes were anticipated), and nine had active polypharmacy prescribed (those currently being evaluated to identify the minimum number of medications required). Nine individuals with residence of less than one year at the Facility had polypharmacy. Updated information for polypharmacy was provided at the 3/20/12 P&T Committee meeting. The stable polypharmacy category remained stable, and had not changed from November 2011 through February 2012. The number of individuals with residence of less than one year on psychotropic polypharmacy saw a gradual decline from November 2011 to February 2012. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 14 of the 30 QDRRs. ▪ Of these, 14 (100%) documented justification with appropriate diagnoses. ▪ All 14 QDRRs (100%) indicated whether side effects or other adverse risks were	

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		present. Anticholinergic Monitoring Of the 30 QDRRs, 30 (100%) were screened for medications associated with potential significant anticholinergic side effects. Ten QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 10 (100%) of cases with this medication prescribed. ▪ All 10 (100%) documented clinical justification. ▪ All 10 (100%) QDRRs addressed side effects/significant risks. New Generation Antipsychotic Endocrine and Metabolic Side Effects Out of the 30 QDRRs reviewed, 12 listed atypical antipsychotic medication. Of these, 12 (100%) included lab values that reviewed endocrine and metabolic risks [i.e., Basic Metabolic Panel (BMP), glucose level, Hgb A1C, and/or lipid panel as appropriate]. For Sections N.2 and N.3, the Pharmacy Department created an internal QA monitoring program. A pharmacist other than the clinical pharmacist reviewed 10 completed QDRRs each month, and determined if there was evidence for each of the indicators listed to ensure the clinical pharmacist reviewed these areas. Indicators included the following: Individual takes an atypical antipsychotic agent, each drug ordered for psychiatric use has an indication on the QDRR, lab monitoring for the atypical agent is present and being monitored, resident takes a drug for which serum levels are routinely monitored, serum levels monitored, resident takes a benzodiazepine, benzodiazepine monitoring is done, polypharmacy is noted by class/use of the drugs, anticholinergic drug use is noted in the QDRR, and low/high lab results noted, if applicable. Monitoring was completed for September 2011 (review date 10/10/11), October 2011 (review date 11/10/11), November 2011 (review date 12/13/11), and December 2011 (review date 1/6/12). Based on the Facility's review, compliance was 100% for each parameter measured in all months. As a general observation, recommendations often confirmed the need to continue monitoring either side effects or lab values/tests, but gave no indication of frequency of testing or review to guide the PCP. For instance, if one were going to suggest monitoring EKGs (for a psychotropic medication), then the frequency and clinical rationale for monitoring (e.g., prolonged QT interval, etc.) would provide clarity to the recommendation for monitoring. Based on the Monitoring Team's review, the QDRRs generally included an appropriate review of the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and monitoring of metabolic and	

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		endocrine risks associated with the use of new generation antipsychotic medications. The term "monitoring" might need further clarification to provide guidance to the PCPs. The area in which the Facility needed to improve to substantially comply with this provision of the Settlement Agreement was in the review of the use of chemical restraints.	
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 30 QDRRs showed the following: ▪ Of the 30, 30 QDRRs (100%) had the PCP signature. ▪ Of the 30, 30 (100%) 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 27 out of 27 (100%). For three, this was not applicable. ▪ Agreement was documented in 27 out of 27. ▪ There was disagreement by the PCP for zero QDRRs. ▪ The PCP reviewed and signed/dated the QDRR within 14 days in 14 out of 30 (47%) of the QDRRs reviewed. ▪ Psychiatry was required to review the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist might also have reviewed other QDRRs. A psychiatrist reviewed 20 QDRRs, and agreement or disagreement with justification and plan was documented in 17 out of 17 (100%). This was not applicable in three QDRRs. The psychiatrist reviewed, signed and dated the QDRR within 14 days in five out of 20 (25%). ▪ It is noted that timeliness in completing the review and sign-off of the QDRRs appeared to be a challenge for both the PCP and psychiatrist. To maintain compliance in future reviews, this issue needs to be addressed. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 laboratory order forms/lab test results for recommendations on the QDRR that identified the need for lab monitoring. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted no active records in which recommendations from the QDRR were not followed. The clinical pharmacist reviewed the QDRRs for October 2011, November 2011, December 2011, January 2012, and February 2012, and found no instance of PCP disagreement with the recommendations listed on the QDRR. The Pharmacy Department created an internal review of the QDRR review process by the PCPs. The process for QDRR review, and verification/monitoring by the Pharmacy Department were submitted for review. This included a series of 18 steps (one step had five sub-components). The focus of the monitoring appeared to be a two-fold purpose.	Substantial Compliance

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		First, there was tracking to ensure the PCP signed and dated each QDRR. There was also recording of agreement or disagreement by the PCP. A similar review was done for those needing psychiatry review and recording of agreement or disagreement. For recommendations made, there also was a follow-up date to determine if the recommendation was completed. Data was submitted for the months of November 2011, December 2011, and January 2012 in monitoring whether the PCP signed and dated the QDRR and whether there was agreement or not with recommendations. For all three months, the Facility's data showed that compliance was 100%. For the month of February 2012, both the PCP and psychiatrist (when appropriate) were monitored for signature and date of review, and whether there was agreement or not with the recommendation. Based on the Facility's data, compliance in signing and dating was 100% for both the PCP and the psychiatrist. Additionally, the PCP and psychiatrist agreed with all recommendations.	
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.	As discussed with regard to Section J.12, the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this was also the latency between the time that the Nurse or Psychiatry Assistant completed the exam and the documentation was reviewed and signed by the prescribing practitioner. The Director of Psychiatry indicated that the nursing staff performed the MOSES evaluations, and the Psychiatry Assistant performed the DISCUS examinations. Prior reports indicated that the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination. The review of the sample of the records of 20 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all but the following four individuals (followed by most recent MOSES completion date): Individual #22 (no MOSES in record), Individual #94 (1/9/12 missing second page signature; no prior MOSES in record), Individual #57 (10/25/11 second page missing; no prior MOSES in record); and Individual #279 (1/12/12, 7/14/11, and 1/24/11 second pages missing). Thus, documentation that the MOSES was completed on schedule was present for 16 of the 20 individuals (80%). The records of the 20 individuals contained documentation that the prescribing practitioner had reviewed the MOSES evaluation in a timely manner for all but six individuals. Those individuals whose MOSES documentation was not reviewed in a	Noncompliance

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		timely manner (latency between dates) were the four individuals described above, and those of: Individual #131 (1/24/11 to 1/12/12); and Individual #7 (7/18/11 to 8/2/11). Thus, the MOSES evaluations were reviewed in a timely manner for 14 of the 20 individuals (70%). The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 19 individuals (Individual #55 was not receiving antipsychotic medication and, thus, monitoring with the DISCUS was not required) identified documentation that the DISCUS was current, and had been performed quarterly for the past year for all but the following two individuals (date of most recent DISCUS evaluation): Individual #94 (no DISCUS in record); and Individual #125 (only 1/17/12 DISCUS in record – no prior documentation found). Thus, documentation that the DISCUS had been performed as specified was present for 17 of the 19 individuals (89%) who required this monitoring. The prescribing practitioner had signed all of the completed DISCUS evaluations that were found in the sample records within seven to 10 days of completion (100%). The numbers and specific information for the individuals whose records comprised this sample have been provided to enable the Psychiatry Department to ascertain if the missing documentation was due to the evaluation not being completed, clerical errors in filing, or omissions of documents in the process of assembling them for this review. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. The Psychiatry Assistant also performed the DISCUS for those individuals who were receiving Reglan, and the Nurse Case Manager performed the MOSES evaluations. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five individuals (21% of those fitting the above criteria) was selected: Individual #312, Individual #181, Individual #260, Individual #191, and Individual #263. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four individuals (80%). The missing documentation was for Individual #312, for whom no documentation of a MOSES evaluation could be found from 2/11/11 until 1/17/12. However, the only individual in this sample for whom the documentation had been signed in a timely manner was Individual #260 (20%). The four individuals for whom there had been a prolonged interval between the completion of the evaluation and the review by the prescribing practitioner were as follows (gap	

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		between evaluation and review): ▪ Individual #312 (2/11/11 to 3/31/11); ▪ Individual #181 (1/3/12 to 1/19/12); ▪ Individual #191 (7/10/11 to 8/1/11); and, ▪ Individual #263 (1/15/11 to 2/10/11, 7/1/11 to 7/28/11, and 1/3/11 to 1/19/11). The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated that these evaluations were completed as specified for all five of the individuals (100%). However, the prescribing practitioner had not uniformly reviewed and signed these evaluations in a timely manner for any of the five individuals in the sample (0%). The interval between the date of the evaluation and the prescribing practitioner review for these individuals was: ▪ Individual #312 (7/14/11 to 7/28/11); ▪ Individual #181 (10/20/11 to 11/2/11, and 7/14/11 to 7/28/11); ▪ Individual #260 (7/15/11 to 7/28/11, and 10/21/11 to 11/2/11); ▪ Individual #191 (10/20/11 to 11/2/11, and 7/14/11 to 7/29/11); and ▪ Individual #263 (10/20/11 to 11/2/11, and 7/14/11 to 7/29/11). During the Monitoring Team's previous review, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing practitioner reviewed and signed them was discussed with the Psychiatry Department. At that time, staff indicated that any abnormal findings on these evaluations were reported immediately to the prescribing practitioner. However, there did not appear to be any documentation of this process. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the prescribing practitioner, it would be useful to devise a mechanism to document this process. The monitoring of individuals prescribed Reglan, but not also receiving a psychotropic agent had improved considerably since the prior reviews. However, there continued to be deficiencies with the prescribing practitioner's timely review of these documents. The finding of noncompliance for this section of the Settlement Agreement related to the deficiencies in the completion of these important side effect monitoring tools, as well as the delays in the timely review by the prescribing practitioner.	
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	The Facility submitted one ADR. It was reviewed at the March 2012 P&T Committee meeting. The ADR involved a rash from Augmentin. The individual was admitted to the hospital for possible Steven's Johnson syndrome. A biopsy confirmed dermatitis unrelated to the medication. The Naranjo probability score was 2. In the six months prior to the Monitoring Team's visit, no other ADR was reported.	Noncompliance

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	significant or unexpected adverse drug reactions.	The clinical pharmacist indicated that the Nurse Educator completed training on the identification of possible adverse drug reactions for nurses and direct support professionals at the time of orientation. This was done as part of the training module entitled: "Observing and Reporting Clinical Indicators of Health Status Change." This was added to the new employee orientation schedule after the mandatory campus-wide training occurred in August 2011. From 8/1/11 through 3/6/12, 749 employees completed this training. The training was not specific to ADRs, but covered changes in health status that would need to be reported/evaluated and would be the first step in identification of an ADR. The submitted copy of the power point included clinical signs and symptoms to observe and report, as well what and how to document. It appeared to provide the necessary depth to a broad topic. The clinical pharmacist was to provide additional training to the Nursing Department concerning the ADR policy and recognition of ADRs. At the time of the Monitoring Team's visit, training had not occurred for over 20 nurses. A compilation of information reviewed at the in-service was submitted. This included an in-depth clinical review of the definition of an ADR, signs and symptoms, drug classes associated with ADRs, patient risk factors, etc. It appeared to be thorough and provided guidance should an ADR be considered to have occurred. It is essential that all nurses successfully complete this training. The most recent training roster submitted for "adverse drug reaction reporting" was dated 3/6/12 and 3/7/12. A sample of a post-training test for nurses, PCP, and pharmacists was submitted.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	A calendar was submitted for the fiscal year 2011-2012 that documented the medications to be included in drug utilization reviews. These included: Metformin - September 2011, anticholinergic utilization in individuals treated with psychoactive or seizure medications – December 2011, Topiramate – March 2012, and Memantine and Donepezil in individuals with dementia - June 2012. The Pharmacy Department provided an update of the calendar for future DUEs. The update included the following medications: September 2012 - Intuniv (Iloperidone), December 2012 - Levofloxacin, March 2013 - Reclast, and June 2013 - Olanzapine. It was unclear why a second drug was included in parentheses for the September 2012 DUE, but the Monitoring Team will follow-up during the next review. At the October 5, 2011 Pharmacy and Therapeutics Committee meeting, the results of the Metformin DUE were discussed. All individuals prescribed Metformin (N=9) were reviewed. The DUE monitored indications for use (i.e., non-insulin dependent diabetes mellitus or other diagnosis justifying use with rationale) contraindications for use (i.e., review of renal function, history of lactic acidosis, hepatic disease, cardiovascular	Substantial Compliance

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		disease, use of glycopyrrolate or cephalexin), and clinical monitoring (i.e., recent serum glucose /Hemoglobin A1c, and recent CBC). All individuals prescribed Metformin had criteria for use, none had any contraindication to it being prescribed, and all had appropriate clinical monitoring. At the December 14, 2011 Pharmacy and Therapeutics Committee meeting, the results of the DUE concerning anticholinergic utilization in those prescribed psychoactive and/or seizure medications was discussed. Ten individuals were chosen for review. Seven were prescribed glycopyrrolate, three were prescribed benztropine, and two of those on glycopyrrolate also were prescribed amitriptylline and glycopyrrolate. Indications for use included treatment of side effects of other medications or neurological condition in all 10 individuals. There were no contraindications for use, and clinical monitoring was reviewed for effectiveness and for side effects. All appeared to have clinical effectiveness (rated as good to moderate relief of side effects). It was noted that all had neurology consultation for side effect monitoring. A second neurologist monitored the individual if there was a seizure disorder. There were no significant side effects that affected the quality of life. Although constipation was not considered severe in any of the cases reviewed, four individuals had been prescribed one laxative and three had been prescribed two laxatives. At the March 20, 2012 P&T Committee meeting, the results of the Topiramate DUE were reviewed. Indications for use, contraindications, precautions and warnings, and clinical monitoring were the focus of the DUE. All had indications for use. Precautions and warnings did not apply to the individuals for which it was prescribed. It was noted that six out of seven had ammonia levels monitored. All seven had hepatic function, secondary glaucoma, renal function, seizure frequency, and serum electrolytes monitored. These DUEs did not require any further follow-up studies to be initiated. LBSSLC remained in substantial compliance with this provision. It was continuing to conduct DUEs that provided valuable information, and the P&T Committee was regularly reviewing the results. A plan was in place to continue the DUEs over the coming year.	
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	As background information, at the October 5, 2011 Pharmacy and Therapeutics Committee, the fiscal year results were discussed for medication variances. There were a total of 612 errors, 348 of which were for medications given but not recorded. The next largest category was medication omissions with a total of 206 events. During the year, 10 “wrong patient” medication errors had occurred.	Noncompliance

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	action regarding actual and potential medication variances.	At the Pharmacy and Therapeutics Committee of 12/14/11, medication errors were discussed from September and October 2011. For Medication Administration Record (MAR) blanks, the RN case managers conducted a weekly review. A number of dosage omissions were identified, but were a small percentage of the MAR blanks. The unit managers were documenting corrective actions for each nurse when incomplete recording was found. For September 2011, a chart indicated the number of medications given, but not recorded per unit as: Unit 1 - 51, Unit II – 177, Unit III - 120. Actual medications omitted were also tabulated as: Unit I - seven, Unit II - 18, Unit III - five. For all three units combined, the total of medications given and not recorded were 348, and the number of medications not given was 30. For the month of October 2011, the number of medications given, but not recorded per unit was documented as: Unit I – 76, Unit II - 109, and Unit III – 31. Actual medications omitted for October 2011 were also tabulated: Unit I - seven, Unit II - 22, Unit III - four. For all three units combined, the total of medications given, but not recorded were 216, and the number of medications not given was 33. For both months, there were no prescribing, transcribing, or dispensing errors. Separately, data was provided for the months of November 2011, December 2011, and January 2012. For the month of November 2011, the number of medications given, but not recorded per unit was as follows: Unit I - 64, Unit II - 132, Unit III – 53. The total for all three units of medication given, but not recorded was 249. The total of medications not given (true omissions) for the three units for November 2011 was 12. For December 2011, the following was the number of medications given, but not recorded per unit: Unit I – 44, Unit II – 119, Unit III – 77. The total of medications for all three units given, but not recorded was 240. For December 2011, the total of medications not given for the three units was nine. For January 2012, the following was the number of medications given, but not recorded for each unit: Unit I – 22, Unit II – none, Unit III – none. The number of medications not given was as follows: Unit I – nine, Unit II - 2, Unit III - none. The total of medications for all three units given, but not recorded was 22. The total of medications for all three units not given was 11. The number of true omissions appeared to be nearly constant through the months of November 2011 through January 2012. The March 20, 2012 P&T Committee provided updated information concerning medication errors. For February 2012, the number of medications given, but not recorded was as follows: Unit I – 24, Unit II – one, Unit III – eight. Total medication variances had dropped from 257 for December 2011, to 34 for January 2012 and 52 for February 2012. The severity score was also available for September 2011 through	

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		February 2012. The error in which the medication was given, but not recorded created a Category A. True omissions were considered Category C. Based on the Facility's data, from the September 2011 through February 2012 time period, 89% of medication errors were due to the medication being given, but not recorded. In nine percent, the medication was not given (Category C). Three individuals also were given the wrong medication (another individual's medications) from September 2011 through January 2012. It was decided that photo cards would be available and be kept over the medication cart in the medication room. The direct support professional bringing the individual to the nurse would also bring a photo card. This allowed correct identification of the individual by the nurse comparing the two photos. Additionally, residential services staff were provided in-service training (dates of four separate training rosters submitted were: 1/12/12 to 1/18/12, 1/12/12 to 1/19/12, 1/17/12 to 1/24/12, and 1/17/12 to 2/8/12), and monitoring was ongoing of the direct support professional's role in the medication pass to ensure cooperation and assistance. Documents submitted for this initiative included a "Training Program Outline," revised 11/16/11, and a "Residential Coordinator Med Pass Monitoring Form," dated 12/29/11. This latter form included specific questions to be answered by the auditor, including: "Was privacy provided for the med pass? Staff verbally ID individual to the nurse passing meds? Nurse verbally ID's individual to the DSP? Did Nurse check picture on MAR before giving med? Did Nurse sanitize his/her hand between individuals?" There was also room for individual comments by the auditor. A review of residential medication pass observations occurred on 2/6/12 and 3/8/12. Minutes were submitted that reviewed identified concerns. Action plans included developing a protocol for infection control issues and individual identification, identifying a location for posting the protocol, and in-servicing staff on use of the protocol. One additional identified concern at the 3/8/12 meeting was the presence of only one staff in charge at a medication pass. For each of the issues, a responsible party and projected completion date was identified. This appeared to be an appropriate approach to addressing these important issues. <u>Returned medications</u> As background, from the October 5, 2011 P&T Committee minutes, there had been no improvement over the fiscal year in returned medications (11 months of data had been reviewed). Steps toward resolving this had included a pharmacy count of medications at the time of distribution. There were no errors noted. The MARS had a number of blanks, but reportedly, the number of medication omissions was not the cause of the large number of returned medications. The number of returned medications needed further investigation by pharmacy and nursing. To refine the process of medication error reporting, the protocol was changed to include timelines. A weekly MAR review was also	

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		initiated in August 2011. The December P&T meeting did not have the November data available, but the September and October 2011 data indicated that Unit 1 had a reduction in numbers, but the other two units had increases. From a chart entitled: "Unexplained returned medication doses (fiscal year 2011-12)," the September data showed the number of returned doses for all Units as 852, which appeared to be inaccurate. It was a combination of adding Unit I tablets, Unit 2 tablets, and Unit III individuals. The more accurate information appeared to be Unit 1 - 205 tablets, Unit II – 617 tablets, Unit III – 222 tablets, with a total for all three units – 1044. A separate document entitled: "Excess Medication Report" listed additional information, breaking down the excess medication returns into numbers of tablets as well as total individuals affected. For Unit III, in one document, 30 returned doses were identified, but these were labeled as 30 total individuals in another document. It is recommended that the data be monitored for quality and content to ensure discrepancies are identified and corrected. The October data indicated the number of returned doses per unit was: Unit I - 149, Unit II - 759. Unit III - 252, with the total for all three units – 1160. The March 20, 2012 P&T Committee provided an update of unexplained returned medication doses. From a submitted table of data, the Facility-wide unexplained returned medications totaled 1282 in November 2011, 959 in December 2011, 730 in January 2012, and 750 in February 2012. Although this showed an overall decrease, the numbers of returned medications continued to be problematic. The Pharmacy Department developed an initiative to reduce the large numbers of returns. It was noted that the number of doses packed in a seven-day supply of medications at times was greater than 200 doses. This presented a challenge for nursing to find the doses and prepare for the medication pass. The pilot program included sending two trays of medications, one for the day shift and the other for the evening shift. This was piloted in one residence with permanent nurses to determine the impact on returned medications. Three additional residences were added in December 2011, and this practice eventually would be extended to all residences. <u>Pharmacy Review of Categorization of Errors</u> Additionally, the Pharmacy Department was active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. For the month of December, the Pharmacy Department completed a QA review of the medication variance severity scores the Nursing Department completed. Medication variance reports from all three units were reviewed, and a sample of those with scores of B or greater were selected. For the	

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		month of December, there were 17 variance reports, and 11 of these were selected for review. The original medication variance reports were retrieved for review as part of this monitoring process. In all 11 of these reviews, the scores of the Nursing Department and the clinical pharmacist were identical. Committee Monitoring of Medication Errors/Variances The development, progress, and tracking of medication error process and trend analysis were reflected in the minutes of the Medication Safety and Systems Committee meetings (i.e., 10/3/11, 10/26/11, 11/16/11, 12/21/11, 1/25/12, and 3/19/12), which the clinical pharmacist chaired. The following describes some of the additional findings of this committee not already reviewed under the discussion of the minutes of the P&T Committee. A number of initiatives were undertaken to reduce medication errors and improve safety. Individual-specific allergy information was in the process of being included on each order sheet for PCP reference when the new orders were being written. The Nursing Department had developed a staffing template for the residences with the goal of keeping the same LVN in each residence as much as possible. As of March 2012, about 75% of the residences had been assigned permanent LVNs. Direct support professional training on identifying individuals and bringing them to the nurse for identification by the nurse was completed, as well training of nurses on the direct support professionals' role/duties in medication passes. Multi-tablet doses were being highlighted on the MARs Medication Error Reports Copies of 13 recent medication error reports were submitted for review. Seven were Category A, two were Category B, and four were Category C. The two medication errors in Category B were true omissions, and the State Office policy indicated that these should have been categorized as Category C. All had nursing administrative follow up submitted except for one, for a compliance of 12 out of 13 (92%). Medication Observation Monitoring The December P&T Committee minutes indicated that for September 2011, there were 18 observations (LVNs – 13, RNs – 5); for October 2011, there were 13 observations (LVNs – seven, RNs – six); and for November 2011, there were 21 observations. Scores ranged from 88% to 100%. Lists for December 2011 and January 2012 of LVNs that had been observed during a medication observation pass were submitted. For December 2011, there were 10 observations for LVNs and seven RN observations (the RN observations included on-the-job training observations). LVNs were observed every three months, according to the tracking document. For January 2012, there were 11 observations, four on-the-job	

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		training observations, and seven as part of the three-month routine observations. For RNs, there were three observations. Scores ranged from 91% to 100%. For February 2012, for LVNs, there were 19 medication administration observations and four RN observations. The range of scores was 94 to 100%. The Pharmacy Department in collaborating with the Nursing Department had made important in-roads to reducing documentation errors. There was continued need for further systems to reduce all medication variances. Problematic was the administration of medication to the wrong individual, and action plans had been created to assist in resolving this problem. Other creative approaches had been used to improve on administration of the correct dosage, especially when more than one tablet was required to complete the dosage. The most common true error remaining appeared to be true omissions, which remained a challenge. The number of returned medications remained problematic. Further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system, and development and implementation of plans to correct issues identified.	

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

1. The Facility should ensure all clinical department personnel assigned clinical responsibilities are certified in CPR. (Section N.1)
2. The screening of new orders for individuals with J-tubes appeared to be problematic. (Section N.1)
3. The Facility should continue to review the various databases for chemical restraints to ensure they are complete, accurate and the content of information is consistent across the databases. (Section N.3)
4. As appropriate, the chemical restraint documentation should include recommendations for changes in maintenance medication or changes in the BSP or environmental factors, etc. (Section N.3)
5. For each chemical restraint form, the Pharmacy Department should answer three questions, including whether it was clinically justified, whether or not medication-related risks exist, 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)
6. In order to maintain compliance during future reviews, the timeliness of the review and sign-off of the QDRRs by both the PCP and psychiatrist should be addressed. (Section N.4)
7. LBSSLC should develop a mechanism to ensure that the prescribing physician reviews the MOSES and DISCUS side effects monitoring forms in a timely manner. (Section N.5)
8. The Pharmacy Department should create a timeline by which all nurses are provided training by the clinical pharmacist on recognition of ADRs. (Section N.6)
9. Further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system, and development and implementation of plans to correct issues identified. (Section N.8)

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 LBSSLC Section O Presentation for Monitors' 4th Compliance Visit March 2012; o The following documents: Occupational Therapy (OT), Physical Therapy (PT), Speech Language Pathology (SLP), and Nutrition assessments; Aspiration Pneumonia/Enteral Nutrition (APEN) assessment; Head of Bed Elevation (HOBE) assessment; Integrated Risk Rating Form; IDT Risk Action Plan; OT/PT/SLP consultations for the last year; Individual Support Plan and ISP Addendums for the last year; Physical and Nutritional Management Plan with written and pictorial instructions; Nursing Care Plans; individual-specific monitoring, for past six months; competency-based training and performance check-offs for staff; and Integrated Progress Notes, for the past six months for 15 individuals (Sample O.1) including: Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #281, Individual #9, Individual #74, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149, and Individual #139; o The following documents: Physical and Nutritional Management Team (PNMT) assessment and action plan, Integrated Risk Rating form, APEN assessment, HOBE assessment, IDT Risk Action Plan, ISP and ISPAs for past year, IDT action plan, supporting documentation for implementation of PNMT assessment and risk action plan, Integrated Progress Notes for the past six months, PNMP with supporting written instructions and photographs, Nursing Care Plans, individual-specific monitoring for the past six months, competency-based staff training and performance check-offs, and PNMT Discharge Plan/Summary (Sample O.2), for the following individuals: Individual #6, Individuals #136, Individual #283, Individual #196, and Individual #323; o The following documents: OT/PT/SLP assessments, APEN assessment, HOBE assessment, nutrition assessment, OT/PT/SLP and Registered Dietician (RD) consultations for the past year, supporting documentation for implementation of pleasure/therapeutic feeding program, ISP and ISPAs for past year, PNMP with written and pictorial instructions, therapy OT/SLP progress notes for pleasure/therapeutic feeding program, individual-specific monitoring for past six months, competency-based training for staff, Integrated Risk Rating form and Risk Action Plan for 10 individuals (Sample O.3), including: Individual #323, Individual #128, Individual #16, Individual #56, Individual #199, Individual #281, Individual #104, Individual #139, Individual #324, and Individual #78; o List of Physical Nutritional Management Team members, including PNMT Coordinator, and curricula vitae, undated; o List of all individuals seen by the PNMT and the corresponding caseload, along with reason(s) for referral to PNMT, undated;

	o Facility PNMT Guideline(s), revised 2/12; o List of continuing education sessions participated in by PNMT members, from 7/11 through 2/12; o Agenda and attendance rosters for clinical instruction and certificates of completion for each staff member, from 7/11 through 2/12; o Minutes and documentation of attendance for PNMT meetings and any other Physical Nutritional Management (PNM)-related teams or committees, from 7/11 through 2/12; o PNMT Evaluation (template), dated 2/12; o Completed PNMT assessment reports, from 1/12 through 2/12; o List of individuals by home who have PNM needs, undated; o List of individuals by home who do not have PNM needs, undated; o Completed PNMPs for all Individuals with identified needs, various dates; o Tools utilized to monitor staff compliance with PNM procedures and plans, dated 2/13/12; o List of individuals for whom PNM monitoring tools were completed, from 8/11 through 2/12; o Tools utilized for validation of the competency of staff responsible for PNM monitoring, various dates; o Data or trend summaries utilized by the Facility related to PNM and/or quality assurance/enhancement reports and corresponding corrective action plans, from 10/11 through 2/12; o Dining Plan (template), revised 2/6/12; o Dining Plans and competency-based training and performance check-off sheets for new and revised Dining Plans, from 12/11 through 2/12; o PNM-related spreadsheets generated by Facility during past 12 months, from 2/11 through 2/12; o List of individuals on modified diets/thickened liquids, dated 2/13/12; o List of individuals who require mealtime assistance, dated 2/10/12; o List of individuals who receive nutrition through non-oral methods, dated 2/29/12; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency, dated 2/9/12; o List of individuals with Body Mass Index (BMI) equal to or greater than 30, undated; o List of individuals with BMI equal to or less than 20, undated; o List of individuals who have had an unplanned weight loss of 10% or greater over a six month period, undated; o List of individuals who have had a choking incident during past 12 months, undated; o List of individuals who have had an aspiration and/or pneumonia incident during past 12 months, dated 2/15/12; o List of individuals who have had chronic respiratory infections during past 12 months, dated 2/13/12; o List of individuals who have chronic dehydration during past 12 months, dated 2/13/12; o List of individuals who have had a fall during past 12 months, undated;

	○ List of individuals who have had a decubitus/pressure ulcer during past 12 months, undated; ○ List of individuals who have experienced a fracture during the past 12 months, undated; ○ 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 video fluoroscopy, modified barium swallow study (MBSS), or other diagnostic swallowing evaluation, from 2/11 through 11/11; ○ Incident reports, assessments, Facility investigations, and all follow-up documentation for any choking or near choking event which occurred from 9/11 through 2/12; ○ Schedule of meals – by home, undated; ○ Schedule of all PNM-related meetings occurring during the week of the onsite review, dated 3/8/12; ○ Curricula on PNM utilized to train new staff responsible for directly assisting individuals including all training materials, various dates; ○ Agenda and curriculum utilized for competency-based in-service training and annual refresher training related to PNM completed from 9/11 through 2/12; ○ Tools and checklists utilized to provide competency-based training and performance check-offs addressing individual-specific PNMPs and Dining Plans, undated; and ○ Summary reports or analyses of monitoring results generated by the Facility related to the PNMT and/or individuals reviewed by the PNMT, from 9/11 through 2/12. ▪ **Interviews with**: ○ Linda Thomas, OT, PNMT Coordinator, Director of Habilitation Therapies (HT); ○ Debbie Jones, CCC/SLP, Dysphagia Specialist, Co-PNMT Coordinator; ○ Corey Verett, RD, LD, Chief Dietician, PNMT Dedicated Member; ○ Latrelle Castanon, RN, PNMT Nurse and Dedicated Member; ○ Melissa Olive, Physical Therapy Assistant (PTA), PNMT Member; ○ Kelley Davis, PNMT Clerk; ○ Jennifer Cunningham, PT; ○ Diane Yanez, PNMT, PNM Coordinator; ○ Sally Schultz, State Consultant; ○ Robin Seale, Assistant Director of Programs; ○ Megan Copeland, OT; ○ Caleb Weston, Unit I Director; and ○ Norma Gutierrez, Safety Representative. ▪ **Observations of**: ○ PNMT meeting, on 3/22/12; ○ Observations in the following residences and day/vocational programs, including dining rooms: 504 East Quail, 504 West Sparrow, 528 North Cedar Avenue Zinnia, 513 South Cedar Aspen, 536 Magnolia Boulevard Workshop, 524 North Cedar Avenue Lilly, 525 North Cedar Avenue Rose, 526 North Cedar Avenue Tulip, 514 South Cedar Avenue Birch, and 539 Lark Street Activity Center.

	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section O of the Settlement Agreement, the Facility found it was in noncompliance with all of the subsections of Section O. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: LBSSLC Self-Assessment, Action Plans, and Provision Action Information. The LBSSLC Self-Assessment listed the steps the Facility staff completed to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The LBSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. The Facility's Self-Assessment had begun to outline a set of data and auditing activities to assess its compliance with the Settlement Agreement. In addition, in a few cases, data had been collected and was reported in the Self-Assessment. These were positive initiatives. However, many of the systems the Facility intended to use had not yet been fully developed, and, as a result, data was not yet available. As the Facility finalizes its self-assessment procedures, it will be important to ensure that indicators reflect the quality of the supports and services, as well as their presence and timeliness. In addition, the Facility should ensure that the indicators are detailed enough to measure the various requirements of the Settlement Agreement. The data produced should be sufficient to assist the Facility in identifying areas in which progress has been made, and those still requiring improvement. The QA/QI Quarterly Summary for Section O for August, September, and October 2011 reported the overall inter-rater reliability scores for August was 94% and September 91%. However, there was no explanation as to how these reliability scores were determined. The summary noted that HT Department monitoring was temporarily deferred in October, November, and December 2011, and January 2012 until additional therapists were hired. Compliance percentages were not provided for individual-specific monitoring indicators for Sections O.1 through O.8. Without this information for August and September, sufficient information and/or data was not available to allow the Facility to analyze its compliance, and identify areas in which progress had been made as well as areas in which work was needed. The Facility should develop and implement a consistent format to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. In addition, the presentation of data should include the total population being reviewed (N), and the sample of the population (n) to yield a percent sample to indicate the relevance of compliance scores.
	Summary of Monitor's Assessment: During the Monitoring Team's last onsite review, the PNMT core members were an Occupational Therapist, Speech Language Pathologist, Physical Therapist, Registered Nurse, Registered Dietician, and Clerk. The former PNMT PT had resigned. In the absence of a PT, the Director of HT assigned the Facility PTA as a new member of the PNMT. However, a PTA did not meet the Settlement Agreement requirement that the PNMT have a physical therapist.

	All five PNMT members attended community continuing education courses and webinars. Attendance rosters, course certificates of completion, and agendas were submitted. The State-sponsored webinars and continuing education courses the PNMT staff attended provided relevant and appropriate clinical instruction for PNMT members. Since the last review, it was positive the Facility had continued to further define the responsibilities of the PNMT and the IDT members. This was a constructive move forward in achieving positive outcomes for individuals at highest risk. These revisions included: PNMT roles at the hospital, responsibilities of the PNMT Clerk, role of the IDT, referral to the PNMT, PNMT self-referral, PNMT timeline to respond to a referral, PNMT timeline for implementation of an action plan, and the PNMT process for an individual's return to the IDT. The revisions were appropriate and provided a relevant expansion of responsibilities for PNMT and IDT members. However, the Monitoring Team has recommended some additions to the guidelines to ensure they comprehensively address the various roles and responsibilities. The PNMT meeting minutes, dated 2/3/12, noted a meeting with the Facility Director to "present systemic issues." It was positive that the PNMT members were bringing these issues forward and working with the Facility Director to seek resolution. The meeting minutes identified individuals who were assigned to work to resolve these identified concerns, as well as follow-up responsibilities. The Facility Director agreed to meet with the PNMT on a monthly basis to review systemic issues and other PNMT concerns. However, no documentation of follow-up meetings was submitted, and/or information about the progress toward resolution of the identified issues/concerns. A list of 218 individuals identified 170 individuals as having PNM needs, and 48 individuals without PNM needs. However, a review the 48 individuals without PNM needs and their PNM risk rating rankings identified that some of these individuals did, in fact, have PNM needs. The PNMP and dining plan format had been revised. The PNMP and dining plan format revisions reflected positive changes from the previous templates. Based on interview with the Director of HT, by October 1, 2012, all individuals' PNMPs and dining plans would be revised. In addition, the Director of HT stated that the revision of PNMPs would provide the opportunity to provide competency-based training and performance check-offs for veteran staff in core PNM competencies. A review of staff instructions in individuals' PNMPs noted improvement in the areas of wheelchair and alternate positioning, time an individual was to remain upright after a meal, bathing/showering, medication administration, and oral care. Recommendations made in the previous report for instructional content to support the attainment of mealtime foundational knowledge and skills had been incorporated into the Mealtime Coordinator (MTC), Feeding and Mealtime Management, and Nutrition Services training curricula. This was a significant positive advancement in the provision of adequate MTC training to support safety at mealtimes. The Monitoring Team observed the presence of Mealtime Coordinators in dining rooms during meal observations. In the previous report, the score for staff's compliance with dining plans during mealtime

	observations was 27%. During this review, the compliance score had increased to 73%, resulting in a significant improvement. Based on interview with the Director of HT, in November 2011, the therapists had initiated a review of the New Employee Orientation (NEO) curriculum to establish which PNM skills would require staff demonstration. This review produced the development of six PNM competency performance check-offs. This was a positive move forward in requiring new employees to complete performance check-offs to test their competency with learned skills. The Facility acknowledged that veteran staff would need to complete these core PNM competency performance check-offs. At the time of the review, the Director of HT was beginning the process of developing a training plan with Unit Managers. Adequate systems were not yet in place for monitoring either staff's compliance with or the effectiveness of individuals' PNMPs, PNMT action plan, and/or risk action plans.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff,	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 evaluations 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 samples for Section O are as follows: ▪ Sample O.1 – seven individuals who had experienced a change in health status as evidenced by an admission to the emergency room or hospital including: Individual #233, Individual #211, Individual #176, Individual #113, Individual #318, Individual #281, and Individual #9; as well as eight of the 44 individuals (18%) ranked at high risk for aspiration including: Individual #74, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149, and Individual #139; ▪ Sample O.2.a – four of the eight individuals the PNMT formally followed (50%) including: Individual #6, Individuals #136, Individual #283, and Individual #196; ▪ Sample O.2.b - one of the two individuals the PNMT discharged (50%), including: Individual #323; ▪ Sample O.3 – 10 of the 43 individuals who received nutrition through non-oral methods (23%), including: Individual #323, Individual #128, Individual #16,	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.</td><td>Individual #56, Individual #199, Individual #281, Individual #104, Individual #139, Individual #324, and Individual #78;
▪ Sample 0.4 – 16 of 44 individuals identified at high risk for aspiration (36%), including: Individual #211, Individual #176, Individual #113, Individual #9, Individual #109, Individual #59, Individual #43, Individual #239, Individual #78, Individual #149, Individual #139, Individual #323, Individual #128, Individual #199, Individual #104, and Individual #324.

<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>
During the Monitoring Team's last onsite review, the PNMT core members were an Occupational Therapist, Speech Language Pathologist, Physical Therapist, Registered Nurse, Registered Dietician, and Clerk.

Documentation of PNMT membership for the current review did not include a PT. A review of the attendance sheets with the PNMT meeting minutes noted the PNMT PT attended 13 of 20 PNMT meetings from 9/1/11 to 10/6/11. A PT was not in attendance for PNMT meetings from 10/10/11 to 2/27/12. The former PNMT PT had resigned. In the absence of a PT, the Director of HT assigned the Facility PTA as a new member of the PNMT. However, a PTA did not meet the Settlement Agreement requirement that the PNMT include a Physical Therapist. It should be noted that during the onsite review, a PT attended the PNMT meeting. However, it was unclear whether or not a PT would begin attending regularly.

The PNMT Nurse and Clerk were dedicated PNMT members. These team members did not have responsibility for a caseload beyond individuals formally followed by the PNMT. The Director of Habilitation Therapy was the PNMT Coordinator and a Speech Language Pathologist was the Co-Coordinator. However, the Facility PNMT Guidelines did not define the role(s) of the PNMT Coordinator and/or PNMT Co-Coordinator. The Facility PNMT Guideline(s) will be discussed in further detail below. The following chart indicates the caseload of PNMT members at the time of the review:

<table>
<tr><th>Core PNMT Members</th><th>Current Caseloads</th></tr>
<tr><td>PNMT Coordinator and Occupational Therapist</td><td>Director of Habilitation Therapy, PNMT Coordinator, supported 41 individuals in 504 East, 504 West, and 517, and individuals on the PNMT caseload</td></tr>
<tr><td>Speech Language Pathologist</td><td>PNMT Co-Coordinator, supported individuals on the PNMT caseload, and supported 38</td></tr>
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	individuals in 504 West and 504 East
Registered Dietician	Chief Dietician and supported individuals on the PNMT caseload
Registered Nurse	PNMT dedicated member, and supported individuals on the PNMT caseload
Physical Therapist	Not assigned
Physical Therapy Assistant	PNMT member, supported 34 individuals in 504 West and 504 East, and individuals on the PNMT caseload
Clerk	Administrative assistant to the PNMT

<u>PNMT members attend relevant continuing education courses.</u>
PNMT core members attended multiple State-sponsored webinars, including:

- On 9/13/11, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, RD, and RN attended the Winning Strategies for Malnutrition in Older Adults from Identification to Intervention;
- On 9/19/11 and 2/1/12, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, RD, and RN attended the Altered GI Anatomy and Function webinar;
- On 9/28/11, the PNMT Coordinator/OT and PNMT Co-Coordinator/SLP attended the Core Training Dietary webinar;
- On 9/29/11, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, RD, RN, and PTA attended the Power of Access Introduction;
- On 10/12/11 to 10/14/11, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, RD, RN and PTA attended the Issues in Evaluation and Treatment of Individuals with Developmental Disabilities/Texas Annual Habilitation Therapy Conference. The first day of the Habilitation Therapies Conference was dedicated to PNMT members. Multiple continuing education courses were presented during the annual HT Conference;
- On 10/21/11, the PNMT Coordinator/OT and PNMT Co-Coordinator/SLP attended Parkinson's Disease – Update from the Expert;
- On 11/9/11, the PTA attended A Good Defense is a Strong Offense: New Insights in Immune Modulating Nutrition;
- On 11/16/11, the PNMT Co-Coordinator/SLP attended Switch Progress – A Road Map;
- On 11/21/11, the RN attended Integration of Clinical Services;
- On 12/7/11, the PNMT Co-Coordinator/SLP, RD, RN, and PTA attended Quality Information System Tools for Success webinar;
- On 1/17/12, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, and PTA attended ConvaTec/Skin Protocol and Supplies;

#	Provision	Assessment of Status	Compliance
		▪ On 2/1/12, the PNMT Co-Coordinator/SLP, RD, and PTA attended Breathing, Digestion, and Swallowing: Best Practices in Dysphagia Management; ▪ On 2/8/12, the PNMT Coordinator/OT, PNMT Co-Coordinator/SLP, RN, and PTA attended Suction Tooth Brushing; ▪ On 2/16/12, the PNMT Co-Coordinator/SLP, RD, and PTA attended Food Additions, Overeating, and Mood Swings; ▪ On 2/17/12, the PNMT Co-Coordinator/SLP attended Children Who Struggle to Speak; and ▪ On 3/7/12, the PNMT Co-Coordinator/SLP attended the Most Integrated Setting training. On a positive note, based on interview with the Director of HT, PNMT members were to complete six hours of continuing education units (CEU) every six months. The Director of HT planned to put this requirement into a formal procedure. However, at the time of the review, this requirement had not been formalized into Facility policy and/or procedure. Five of the five PNMT members (100%) attended community continuing education courses and webinars. Attendance rosters, course certificates of completion, and agendas were submitted. The State-sponsored webinars and continuing education courses the PNMT staff attended provided relevant and appropriate clinical instruction for PNMT members. <u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> The Facility PNMT Guideline(s), revised February 2012, stated: "PNMT members meet at least weekly to review active cases and begin [an] assessment for new referrals." A review of PNMT meeting attendance sheets noted the PNMT met weekly with the exception of the week of December 26, 2011. However, wide discrepancies were noted with regard to attendance percentages amongst the respective members. For example, the highest attendance percentage was the PNMT RN at 88%, and the lowest was the PNMT PT at 12%. For the time period from 9/1/11 to 2/27/12, documentation showed that the PNMT conducted 106 individual-specific meetings. Documentation indicated the PNMT met from one to three times during a week. Attendance by the core team members was as follows: • PNMT Coordinator/OT: 52%. Multiple attendance sheets (25%) indicated that the PNMT Coordinator did not attend, but "reviewed with PNMT." • PNMT Co-Coordinator/SLP: 73%; • PNMT RD: 75%; • PNMT RN: 88%;	

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		• PNMT PT: 12%; • PNMT PTA: 68%; • PNMT Clerk: 85%; • Facility Primary Care Physician: 16%; • Facility QDDP: 87%; • Facility RN Case Manager: 78%; and • Facility Residential Coordinator: 63%. The meeting attendance percentages for some of the core PNMT members showed that they did not participate in PNMT meetings on a regular basis. The Director of HT should ensure core PNMT members participate in PNMT meetings on a regular basis. Based on interview with the PNMT, a Facility physician was designated as the medical liaison to the PNMT. However, the PNMT meeting attendance sheets and meeting minutes did not indicate ongoing PNMT consultation with the Facility medical liaison. The PNMT meeting minutes, dated 2/3/12, noted a meeting with the Facility Director to "present systemic issues." It was positive that the PNMT members were bringing these issues forward and working with the Facility Director to seek resolution. The systemic issues included infection control related to cross contamination, expedition of individual-specific orders, completion of APEN assessment by required disciplines, need for IDTs to follow PNMPs and PNMT recommendations, IDTs' cancellation of PNMT meetings, responsibility for monitoring individuals who receive enteral nutrition, nursing staff providing suction tooth brushing, limited access to specific medical documentation, identification of set PNMT meeting time for IDTs, and importance of Integrated Progress Note documentation. Due to the PNMT's primary focus within these residences, the majority of the issues and/or concerns raised were focused on 504 West and 504 East. These meeting minutes identified individuals who were assigned to work to resolve the identified concerns, as well as follow-up responsibilities. The Facility Director agreed to meet with the PNMT on a monthly basis to review systemic issues and other PNMT concerns. However, based on the documentation provided, no further meetings with the PNMT and the Director had occurred. The PNMT should document the status on resolution of systemic concerns in the monthly meetings with the Facility Director. At the time of the review, the Director of HT submitted a revised active PNMT caseload list. The revised list noted eight individuals were on the active PNMT caseload (i.e., Individual #226, Individual #312, Individual #136, Individual #6, Individual #176, Individual #283, Individual #29, and Individual #196). Since the last review, six of these eight individuals had been admitted to the emergency room and/or hospital. Facility PNMT Guideline(s) included a listing of PNMT roles at the hospital, including review of	

#	Provision	Assessment of Status	Compliance
		an individual's positioning, ensuring the individual's book and equipment were present, providing support to the individual and the direct support professional, and communicating with the Facility Nurse Liaison. This addition was a positive development. However, these guidelines did not describe the PNMT responsibilities for an individual after he/she was discharged from the hospital. Given that a hospitalization would be considered a change in status, it would be expected that for individuals on the PNMT caseload, a review would be conducted and necessary assessments initiated within the five working days set forth in Section I of the Settlement Agreement. A review of the PNMT attendance meeting sign-in sheets found the following: ▪ These six individuals had multiple admissions to the emergency room (ER) and/or hospitalizations. On a positive note, the PNMT and some IDT members (i.e., QDDP, Nurse Case Manager, Residential Coordinator) met the timeline of meeting within five working days to discuss an individual's change in status for some of the individuals who had been discharged from the hospital. However, there were discharge dates when the IDT and PNMT did not meet within five working days. For example: o Individual #6 had a hospital discharge date of 11/14/11, and an ER visit on 1/1/12. The PNMT did not meet within five days of these discharges. o On 10/11/11, Individual #226 was discharged from the hospital. The PNMT met on 10/24/11, nine working days after his discharge; o On 2/8/12, Individual #312 was admitted to the ER, but there was no report of his discharge date. The PNMT met on 2/16/12. However, it could not be determined if the PNMT met within five working days; and o On 11/14/11, Individual #196 was discharged from the hospital, but the PNMT did not meet until 1/12/12. Within the section of PNMT Roles at the Hospital, the Facility PNMT Guideline(s) should define the IDT and PNMT responsibilities for individuals on their caseload who are hospitalized. The guidelines should reference the IDT and PNMT's responsibilities as noted in the State At-Risk Individuals policy for change of status. Since the last review, it was positive the Facility had continued to further define the responsibilities of the PNMT and the IDT members. This was a constructive move forward in achieving positive outcomes for individuals at highest risk. These revisions included: PNMT roles at the hospital, responsibilities of the PNMT Clerk, role of the IDT, referral to the PNMT, PNMT self-referral, PNMT timeline to respond to a referral, PNMT timeline for implementation of an action plan, and the PNMT process for an individual's return to the IDT. The revisions were appropriate and provided a relevant expansion of responsibilities for PNMT and IDT members. Based on a review of documentation, the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team recommends the following additions to the PNMT Guideline(s): ▪ Require IDT members to refer individuals who are at risk of receiving a feeding tube to the PNMT; ▪ Establish attendance thresholds for core PNMT members; and ▪ Incorporate the requirement for the PNMT to meet within five working days for individuals discharged from the ER and/or hospital. At the time of the review, IDT members had not been trained on the revised Facility PNMT Guideline(s), as noted in the Facility's Action Plan for Section O.1. The implementation of this training is vital to ensure IDT members understand the importance of their role in the PNMT referral process. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>A process is in place that identifies individuals with PNM concerns.</u> Per Facility PNMT Guideline(s), the IDT and or the Primary Care Physician were to refer individuals to the PNMT who were at high risk and not stable, and for whom the IDT required assistance in developing a plan and/or for an assessment. The IDT and/or PCP were responsible for completing a PNMT consultation referral form and submitting the following documentation: ▪ Reason for referral, and request for assistance and/or assessment; ▪ Health data information; ▪ Current assessment(s) related to identified risks; ▪ Risk ratings and rationales; ▪ Action plan the IDT developed; and ▪ ISPAs with documented discussions referring to the IDT action plan. The PNMT also could initiate a self-referral after reviewing any of the following, but not limited to: hospitalizations, any instance of aspiration pneumonia/respiratory compromise, and/or other changes in status. The addition of the procedures for referrals from IDT members, PCPs, and the PNMT was a positive step in further defining the role of the IDT, PCP and the PNMT in identifying individuals with PNM concerns. However, as stated above in Section O.1, additional information should be incorporated into the Facility PNMT Guideline(s), and staff training should be provided to IDT members on these guidelines. The Facility's Self-Assessment for Section O.7 identified activities that should assist the Facility in improving its process for identifying individuals with PNM concerns. These activities included a quarterly analysis of individuals who had visited the emergency	Noncompliance

#	Provision	Assessment of Status	Compliance
		room and/or had been admitted to the hospital. In addition, the Facility was to develop protocols for weekly meetings to enable an analysis of trends. This Facility analysis was expected to provide recommendations to the IDTs for the revision of individual interventions. Furthermore, the implementation of a PNMT audit tool should assess IDT and PNMT compliance with PNMT referral guidelines. The implementation of these processes should strengthen the Facility's ability to identify individuals and refer individuals with significant PNM concerns to the PNMT. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment 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> At the time of the review, as noted above, the active PNMT caseload was eight individuals. The PNMT provided IDT consultation for the following additional nine individuals: Individual #235, Individuals #210, Individual #114, Individual #225, Individual #171, Individual #191, Individual #263, Individual #215, and Individual #89. The Facility PNMT Guideline(s) did not define the PNMT responsibilities for providing consultation to IDTs. The Monitoring Team reviewed Integrated Risk Rating Forms, PNMT assessments, PNMT Risk Action Plans, Integrated Health Care Plans and additional supporting documentation for four of the eight individuals (i.e., Individual #6, Individual #136, Individual #196 and Individual #283) on the active PNMT caseload in Sample O.2a and found: ▪ In four of the four individual records reviewed (100%) documentation was present of a PNMT self-referral and/or IDT referral date. However, the IDTs did not refer and/or the PNMT did not initiate timely self-referrals for Individual #196, Individual #136, and Individual #6. These individuals had been hospitalized multiple times and/or had experienced significant changes in status prior to the PNMT initiating a self-referral. Although for two of these individuals (i.e., Individual #136 and Individual #196), the PNMT was providing consultation to their teams, the multiple hospitalizations were signs that the individuals were not stable, and the teams required additional assistance in the assessment and plan development process. ▪ In three of the four individual records reviewed (75%), there was documentation of adequate PNMT review of an individual's risk levels during the comprehensive PNMT assessment process, and updating of the risk rating, as appropriate. For one individual (i.e., Individual #136) the risk rating form had been completed over three months before the PNMT assessment, and documentation was not available to show that it had been thoroughly reviewed and updated. ▪ In three of four individual records reviewed (75%) an adequate APEN	

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		assessment had been completed. Individual #283's APEN assessment reported "currently under review by the PNMT." ▪ In four of the four individual records reviewed (100%) an adequate HOBE assessment had been completed. The assessment results provided safe elevation ranges for wheelchair and alternate positioning, bathing, tooth brushing, and medication administration. These results had been integrated into individuals' PNMPs. ▪ In one of the four individual records (i.e., Individual #136) reviewed (25%), individual-specific clinical baseline data were established to assist teams in recognizing changes in health status. ▪ In none of the four individual records (0%) were individualized clinical criteria defined regarding when nursing staff should contact the PNMT. On a positive note, individuals' PNMPs identified risk-related triggers, but these triggers were not consistently addressed in PNMT assessments, risk action plans, and/or nursing care plans. Individual-specific clinical criteria should be integrated into nursing care plans. The PNMT action plan and/or integrated care plan should define when nursing staff should contact the PNMT. ▪ In two of the four individual records reviewed (50%) (i.e., Individual #196 and Individual #6), an adequate PNMP was present that provided strategies to minimize high and medium risk indicators. The only missing component in Individual #283 and Individual #136's PNMPs were staff instructions for personal care. The PNMPs had been revised to reflect the new PNMP format. These individuals' PNMPs were a significant improvement from the previous review. ▪ For four of the four individuals (100%), a PNMT/IDT meeting had been conducted within established timeframes to discuss the Integrated Risk Rating Form, PNMT Assessment, and action plan. PNMT/IDT attendance sign-in sheets documented participation with IDT members such as the QDDP, RN Case Manager, Residential Coordinator. ▪ In none of the four individual records reviewed (0%) was the PNMT action plan adequately integrated into the ISP. PNMT action plans did not provide adequate integration between the appropriate disciplines. For example, Nursing Care Plans for these individuals did not integrate PNMT strategies. <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> It should be noted that this heading previously was discussed under Section O.6. However, it was moved to this section because it is more relevant here. The PNMT Guideline(s) stated that a major responsibility of the PNMT nurse was to attend the morning medical meetings to keep abreast of changes in individuals' status.	

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		The PNMT nurse's responsibility was to alert the PNMT and HT therapists of any individual cases of aspiration pneumonia and changes in health status that were pertinent to the PNMT and HT therapists. The attendance of the PNMT nurse at morning medical meetings should also assist the Facility in enhancing the process of identifying individuals with PNM concerns. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
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> At the time of the onsite review, the current census of LBSSLC was 220 individuals. A list of individuals with and/or without PNM needs was submitted that included a total of 218 individuals. One hundred and seventy (170) of 218 individuals (78%%) were identified with PNM needs. The list identified 48 of the 218 individuals (22%) as not having PNM needs. The Monitoring Team reviewed the LBSSLC Risk Ranking Data by Home, dated 3/8/12, which identified individuals with PNM high and/or medium risk indicators (i.e., choking, aspiration, respiratory compromise, falls, fractures, osteoporosis, weight and skin integrity). The following observations were noted: ▪ The Facility ranked the following individuals at medium risk for aspiration: Individual #271, Individual #115, Individual #264, Individual #31, Individual #26, and Individual #99. The individuals were identified as having "no PNM needs." These individuals should be reassessed to determine their need for a PNMP to provide staff with strategies to minimize their risk of aspiration throughout the 24-hour day. ▪ Individuals evaluated as being at high or medium risk for choking were identified as not having PNM needs, including the following individuals: Individual #151, Individual #19, Individual #119, Individual #310, Individual #31, Individual #174, Individual #202, Individual #146, and Individual #26. Individuals at high and/or medium risk for choking should be reassessed to determine if they require a PNMP and/or dining plan to provide staff strategies to minimize their risk of choking. ▪ The following individuals were identified as not having PNM needs, but were rated at medium risk for falls: Individual #143, Individual #306, and Individual #266. These individuals should be reassessed to clarify if they require a PNMP. ▪ Individual #74 was identified with "no PNM needs," but was ranked at high risk for skin integrity. Furthermore, Individual #174's Integrated Risk Rating results ranked him at high risk for choking, diabetes, fluid imbalance, fractures, gastrointestinal (GI) concerns, hypothermia, osteoporosis, seizures, and urinary tract infections. He was ranked at medium risk for aspiration, cardiac,	Noncompliance

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		challenging behavior, circulatory, constipation, falls, and weight. According to his risk ratings, this individual had significant PNM concerns, but did not have a PNMP or dining plan. Based on the examples above, individuals who had been identified with "no PNM needs" did, in fact, have PNM needs. The HT Department should develop procedures that define the PNM criteria for individuals who require a PNMP, including a dining plan. These criteria should incorporate the relevant PNM risk indicators that require development and implementation of a PNMP. These PNM criteria should be utilized to review the list of 48 individuals with "no PNM needs" to determine which, if any, of these individuals meet the PNM criteria require an adequate PNMP. Based on interview with the Director of HT and review of documentation submitted, the PNMP and dining plan format had been revised. The revised dining plan format added individual-specific risks and triggers, which was a positive development. This information should continue to heighten staff knowledge of individuals' risk factors, as well as providing triggers to alert staff that an individual is experiencing a change of status during mealtimes. At the time of the review, 10 individuals' dining plans had been revised to incorporate these changes. The PNMP format revisions reflected significant positive changes from the previous PNMP template. The revised PNMP format included the following: an individual's outcome, risks and triggers; listing of assistive equipment and the reason for the equipment; medication administration instructions, which included position, texture, fluid, and strategies; oral care for the individual and dental staff; dining plan; positioning/repositioning; transfer, mobility, and movement; skin care; and communication. At the time of the review, 37 of the 178 individuals' PNMPs (21%) had been revised to reflect the new PNMP format. According to the Director of HT, by October 1, 2012, all individuals' PNMPs and dining plans would be revised. However, no incremental timeline was presented to reflect how many individuals' PNMPs would be completed from month to month. In addition, the Director of HT stated that the revision of PNMPs would provide the opportunity to complete competency-based training and performance check-offs with veteran staff in core PNM competencies. However, at the time of the review, this training plan had not been formalized. The PNMPs for the 15 individuals in Sample O.1 were reviewed. All of these individuals had a PNMP. However, some essential components were missing: ▪ Fifteen of the 15 individuals in Sample O.1 (100%) had a PNMP. ▪ Fourteen of the 15 individuals' PNMPs (93%) were current within the last 12	

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		months. Individual #149's PNMP, dated 10/21/10, was not current. ▪ Nine of 15 individuals' PNMPs (60%) noted individual-specific risks and related triggers. ▪ In 15 of 15 individuals' records (100%), the PNMPs included adequate positioning instructions for wheelchair and alternate positioning, including strategies for safe elevation ranges. ▪ In 15 of 15 individuals' records (100%), the PNMPs included adequate transfer instructions. ▪ Based on a review of a subset of seven individuals who ate orally,(i.e., Individual #233, Individual #113, Individual #318, Individual #109, Individual #59, Individual #239, and Individual #149), seven individuals (100%) had adequate mealtime/dining plans that included written and/or pictorial instructions for positioning, food texture, fluid consistency, and staff presentation techniques. ▪ In 13 of 15 individuals' records (87%), the PNMP included the time an individual needed to remain upright after eating and/or receiving enteral nutrition. Individual #211 and Individual #59's PNMPs did not provide instructions to alert staff to the amount of time the individuals were to remain upright after receiving a meal. ▪ In 11 of 15 individuals' records (73%), the PNMPs included adequate strategies for medication administration. Individual #318 and Individual #239's PNMPs did not have medication administration instructions. Individual #59 and Individual #149's PNMP noted: "instructions for eating, medication administration and oral care are included with PNMP pictures/instructions," but these instructions were not submitted with the record request. ▪ In 13 of 15 individuals' records (87%), the PNMPs included adequate strategies for oral hygiene. Individual #318 and Individual #239's PNMPs did not provide instructions for the individuals' positioning during oral care and/or for dental staff. ▪ In 15 of 15 individuals' records (100%), the PNMPs included a listing of individual adaptive equipment. ▪ In eight of 15 individuals' records (53%), the PNMPs included adequate bathing/showering positioning and related instructions. The PNMPs for Individual #233, Individual #211, Individual #318, Individual #109, Individual #59, Individual #239, and Individual #149 did not have adequate instructions for staff to achieve the prescribed range of elevation in bathing/showering equipment. ▪ In one of 15 individuals' records (7%), the PNMP included adequate personal care instructions, with elevation strategies during checking and changing. More specifically, Individual #9's PNMP provided positioning instructions to be used during the provision of personal care. ▪ In 15 of 15 individuals' records (100%), the PNMPs included communication	

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		strategies. Based on interview with the Director of HT, the provision of HOBE assessments for individuals were to be prioritized into three sequential categories: individuals who received enteral nourishment, individuals who had a diagnosis of aspiration pneumonia and/or pneumonia, and individuals with slow gastric emptying. These assessment recommendations would be integrated into individuals' PNMPs. However, at the time of the review, no schedule had been developed for the implementation of HOBE assessments for individuals within these categories. Even though this initiative had not been implemented, it was positive that completion of HOBE assessments would be expanded beyond individuals the PNMT formally followed. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the Settlement Agreement components.</u> It should be noted that in previous reports, this heading was addressed in Section O.8, but has been moved here due to its greater relevance with Section O.3. The PNMPs for a subset of seven individuals who received enteral nutrition in Sample O.3 (i.e., Individual #323, Individual #128, Individual #16, Individual #56, Individual #199, Individual #104, and Individual #324) were reviewed and some components were missing. More specifically: ▪ Seven of the seven individuals in this subset of individuals in Sample O.3 (100%) had a PNMP. ▪ Seven of the seven individuals' PNMPs (100%) were current within the last 12 months. ▪ Five of seven individuals' PNMPs (71%) noted individual-specific risks and related triggers. Individual #56 and Individual #99's PNMPs did not have individual-specific risks and triggers. ▪ In seven of seven records (100%), individual PNMPs had adequate positioning instructions for wheelchair and alternate positioning, including additional written and pictorial strategies to achieve an appropriate elevation range. ▪ In seven of seven individuals' records (100%), PNMPs had adequate transfer instructions. ▪ In six of seven records (86%), individuals' PNMPs had adequate staff instructions to identify the prescribed time an individual was to remain upright after completing a meal or receiving enteral nutrition. The PNMP for Individual #56 did not specify the time the individual was to remain upright after a meal. ▪ In five of seven records (71%), individuals' PNMPs had adequate instructions for nurses to support safety during medication administration. The medication administration instructions in Individual #56 and Individual #199's PNMPs needed additional information for texture, fluid, and strategies.	

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		▪ In seven of seven records (100%), individuals' PNMPs had adequate strategies for oral hygiene. ▪ In seven of seven individuals' records (100%), individuals' PNMPs listed adaptive equipment. ▪ In five of seven records reviewed (71%), individuals' PNMPs had adequate bathing/showering positioning instructions. Staff instructions to achieve safe bathing/showering equipment elevations were not present for Individual #56 and Individual #199. ▪ In none of seven records (0%), individuals' PNMPs listed adequate personal care instructions to achieve elevation range during checking and changing. ▪ In seven of seven records reviewed (100%), individuals' PNMPs recommended communication strategies. A review of these individuals' PNMPs noted improvement since the last review in the areas of wheelchair and alternate positioning, time an individual was to remain upright after a meal, bathing/showering, medication administration, and oral care. The Facility self-assessment indicated PNMPs and dining plans were audited. However, based on an interview with the Director of HT, the PNMP and dining plan audit tool had not been finalized. The PNMP and dining plan audit tool should be finalized and implemented. The plan to audit PNMPs and dining plans was a positive step forward in assessing compliance with the quality and provision of key elements in individuals' PNMPs and dining plans. <u>PNM plans were incorporated into individuals' ISPs.</u> A review of the 10 individuals' ISP attendance sheets in Sample O.3 found: ▪ Medical attendance was 100% (10 of 10 meetings); ▪ Nursing attendance was 100% (10 of 10 meetings); ▪ Dental staff attendance was 40% (four of 10 meetings) ▪ Occupational Therapist attendance was 30% (three of 10 meetings); ▪ Physical Therapist attendance was 40% (four of 10 meetings): ▪ Physical Therapy Assistant attendance was 20% (two of 10 meetings); ▪ Speech Language Pathologist attendance was 60% (six of 10 meetings); ▪ Registered Dietician attendance was 70% (seven of10 meetings); and ▪ Direct support professional attendance was 40% (four of 10 meetings). As a result of vacant therapy positions, the Director of HT required the attendance of only one therapist, who was responsible for representing HT at the individual's annual ISP meeting. Multiple signature sheets noted that only one of three of the individuals' therapists (OT, PT and SLP) attended an annual ISP meeting. The attendance of only one therapy professional at an annual ISP meeting should be reevaluated. The absence of	

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		these professionals impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff and direct support professionals impacted the ability of the IDT to adequately review and integrate an individual's PNMP into the ISP. Direct support professionals are responsible for the implementation of PNMPs and dining plans. Their significant contribution to the content of a PNMP and/or dining plan should not be underestimated. Having a direct support professional in attendance with a strong relationship with an individual and who has provided support to the individual would provide invaluable information. These professionals have knowledge regarding how an individual responds to activities in their daily routines. For example, a direct support professional would be able to help the team define how an individual who cannot verbally communicate expresses their discomfort or shows physical signs that might indicate the onset of an illness. This information should be integrated with the triggers on the individual's PNMP and dining plan. In addition, direct support professionals should have the opportunity to discuss PNMP and dining plan strategies that might not be effective and/or request clarification on how to implement a strategy. This should lead to a dynamic discussion resulting in acceptance and/or revision of the proposed PNMP and dining plan strategies. Furthermore, dental staff play an important role in providing information regarding the current oral hygiene status of the individual. As a result, changes to an individual's oral care services and/or supports might need to be made. An important component of integration of PNM plans into ISPs involves the discharge planning process for individuals on the PNMT caseload. The Facility PNMT Guideline(s) section entitled PNMT Return to the IDT noted: "when the individual has met the stated objective as determined by the IDT/PNMT and the associated risks have been stabilized or reduces with the interventions in place, the IDT will be responsible for the continuation of the plan." The PNMT was responsible for discussing with the individuals' IDT members the presentation of assessment data, evidence and efficacy data for the PNMT action plan, monitoring results, competency-based training documentation, recommendations and implementation guidelines for ongoing monitoring, proposed review schedule, and criteria for reassessment by the PNMT. These discharge guidelines for the PNMT and the IDT were an important and positive addition to the Facility's PNMT Guideline(s). As noted with regard to Section O.1, the Facility had identified that IDT members will require training on the revised Facility PNMT Guideline(s). The Monitoring Team agrees that IDT members should receive training on these guidelines. In addition, the PNMT audit tool should incorporate indictors to substantiate compliance with the Facility PNMT Guideline(s). Since the last review, the PNMT had discharged two individuals (i.e., Individual #323 and Individual #258). The Monitoring Team reviewed Individual #323 in Sample O.2.b. The	

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		following summarizes the findings based on this review: ▪ The PNMT Coordinator/OT, Co-Coordinator/SLP, RD, RN, PTA, and Clerk signed the PNMT Follow-Up, dated 3/15/12. The PNMT Follow-Up's Plan of Action noted Individual #323 was to be discharged from the PNMT, IDT was to continue to monitor per the current action plan timelines and designations, the IDT was to refer to "PNMT upon change of status requiring PNMT collaboration per PNMT referral guidelines." However, no ISPA meeting was held with Individual #323's IDT members to address the Facility PNMT Guideline(s). Furthermore, a review of the PNMT Follow-Up identified multiple concerns: o Multiple PNM high and medium risks were identified. A review of his risk action plan noted that these risk areas were not adequately addressed; o The PNMT SLP reported that his Aspiration Trigger Sheet had not been completed for the month of March. Staff were not aware where the sheet was located or what to document. The PNMT SLP, QDDP and Residential Case Manager initiated competency-based training "on the spot;" o The Residential Case Manager reported that his ammonia levels had not been checked since the last PNMT/IDT meeting; and o His APEN assessment required further editing and updating. However, the "IDT and PNMT agree that PNMT consult is no longer needed regarding [Individual #323's] daily care unless there is a change in health status or if the IDT feel there is a concern that needs PNMT attention." The PNMT did not follow the established procedures in the Facility PNMT Guideline(s). Based on interview with the Director of HT and a self-assessment activity, a PNMT audit tool was finalized. Individuals discharged from the PNMT should be audited to ensure compliance with the Facility PNMT Guideline(s). <u>PNMPs are reviewed annually at the ISP meetings, and updated as needed.</u> A review of the 10 individuals' ISPs in Sample O.3 found PNMP content was listed in the ISP. However, there was no evidence that IDT members had discussed the efficacy of the interventions and integrated PNMP strategies into other plans and activities (e.g., action plans, skill acquisition programs, behavior support plans, nursing/health management care plans, and/or daily schedules). <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> A review of a subset of six individuals' PNMPs in Sample O.3 that had been revised after their annual ISP meeting (i.e., Individual #323, Individual #128, Individual #56, Individual #199, Individual #78, and Individual #281) found:	

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		▪ None of the six individuals' revised PNMPs had been discussed at an ISPA meeting. Without an ISPA meeting, IDT members did not have the opportunity to discuss, offer input, and/or approve the PNMP revisions. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's finding. The 48 individuals identified with no PNM needs should be re-assessed to determine if they meet the criteria. The revision of PNMPs and dining plans should continue. The PNMP and dining plan audit tool had not yet been finalized and implemented. Having only one therapist representing HT during an annual ISP meeting was problematic for some individuals. PNMT discharge processes were not yet being followed consistently. In addition, individuals' PNMPs and dining plans had not yet been adequately integrated into individuals ISPs' and ISPAs were not consistently held when changes were needed.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> The Monitoring Team observed staff implementation of PNMPs and dining plans in the following activity centers, vocational center, and residences, including dining rooms: 504 East Quail, 504 West Sparrow, 528 North Cedar Avenue Zinnia, 513 South Cedar Aspen, 536 Magnolia Boulevard Workshop, 524 North Cedar Avenue Lilly, 525 North Cedar Avenue Rose, 526 North Cedar Avenue Tulip, 514 South Cedar Avenue Birch, and 539 Lark Street Activity Center. The Monitoring Team also observed a nurse completing two individuals' medication passes. During these observations, examples were noted of staff's compliance and/or noncompliance with PNMPs and dining plan strategies. The Monitoring Team observed the following 19 individuals: Individual #195, Individual #136, Individual #139, Individual #192, Individual #205, Individual #116, Individual #265, Individual #198, Individual #73, Individual #161, Individual #179, Individual #53, Individual #175, Individual #222, Individual #58, Individual #299, Individual #298, Individual #79, and Individual #13 in their residences and dining rooms. The Director of HT and the State Consultant accompanied the member of the Monitoring Team for meal observations in Tulip and Rose residences. The following summarizes the results of observations for these individuals: ▪ In 11 of 15 observations of individuals during mealtimes (73%), staff was compliant with dining plans instructions for positioning, food texture/fluid consistency, use of adaptive equipment, and/or presentation techniques. ▪ In none of one observation (0%) did staff complete a pivot transfer correctly. ▪ In none of three observations for medication administration (0%) did the nurse follow the PNMP and/or dining plan instructions for medication administration.	Noncompliance

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		The Monitoring Team observed the presence of a Mealtime Coordinator in dining rooms during meal observations. The performance of Mealtime Coordinators differed from residence to residence. The strongest performance of MTCs was in the Zinnia and Aspen residences. However, the Monitoring Team did observe MTCs repositioning individuals before and during the meal, verifying that individuals received their prescribed mealtime adaptive equipment, checking individuals to ensure their food and fluid had been prepared according to the correct diet texture and fluid consistency, and coaching staff when they were not following an individual's dining plan presentation techniques. The performance of MTCs was significantly improved as compared to the Monitoring Team's last review. In addition, the compliance score for staff's implementation of dining plans during mealtime observations in the previous report was 27%. During this review, the score of 73% for staff compliance with individuals' dining plan instructions was a significant improvement. The Medication Administration Observation form had been revised to include seven questions related to the nurses' implementation of the PNMP during administration of medication. The nurse was to 1) ensure the presence of the PNMP in the medication administration record; 2) refer to the PNMP prior to the presentation of medication; 3) ensure assistive and positioning equipment were present and being utilized correctly; 4) be able to verbalize who to contact if problems with equipment were identified; 5) ensure individual was in the proper position prior to medication administration; 6) be able to verbalize the rationale between the medical diagnosis and the PNMP; and 7) communicate with the individuals before, during and after presentation of medication. The monitoring of these PNMP indicators was a positive addition. However, no information was provided regarding the completion of competency-based training and performance check-offs for nursing staff. This would be necessary to test their competency with regard to the core PNM competencies, such as being able to demonstrate optimal alignment and support for an individual in wheelchair and alternate positioning, correct presentation techniques as prescribed on a dining plan, and recognition of the correct diet texture and fluid consistency. The Monitoring Teams' observation of a nurse incorrectly presenting medication orally to Individual #195 reinforced the need for nurses to successfully complete competency performance check-offs. The nurse did not follow the dining presentation techniques, and also presented food when the individual's head was in hyperextension. These incorrect techniques had the potential to place the individual at risk of aspiration. Based on interview, nursing auditors had not been provided PNM core competency-based training and performance check-offs to test their competency in auditing these	

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		indicators. A review of the Medication Observation form for Individual #195, which a nurse auditor completed while the Monitoring Team was conducting its observations, indicated that the nurse referred to the PNMP prior to the presentation of medication. However, the nurse did not follow the dining plan presentation techniques, and this was not included on the monitoring form. The Medication Observation form should include an additional indicator to alert the nurse auditor to make sure the nurse reviews the dining plan for individuals who take medication orally. In addition, the nurse should use the prescribed mealtime techniques during the presentation of medication. The Director of HT should collaborate with the Chief Nurse Executive to develop a plan for providing competency-based training and performance check-offs for the Facility nurses. The training should cover wheelchair and alternate positioning, mealtime presentation techniques, purpose and use of mealtime adaptive equipment, and diet textures and fluid consistencies. The Monitoring Team met with representative members of the Mealtime Improvement Committee (MIC) for an update on what the committee had accomplished since the last review. The ADOP, Unit I Director, Safety Representative, and an OT were in attendance. The Director of HT and a State Consultant also attended the meeting. Based on this meeting, the following steps had been taken: ▪ The Mealtime Coordinator Curriculum had been developed and finalized; ▪ The MTC training was field tested on the Mock Survey Team; ▪ Feedback from the Mock Survey Team resulted in additional revisions to the MTC training; ▪ MTC training was provided to 65 direct support professionals/MTCs, 15 Residential Coordinators, and PNMP Coordinators; ▪ A team of two staff (i.e., one representative from Residential and a therapist) completed performance check-offs for 18 Mealtime Coordinators; and ▪ To date, seven of 65 MTCs (11%) had successfully passed the MTC performance check off. At the time of the review, 18 MTCs had been tested. Seven of the 18 MTCs had successfully passed the MTC performance check-off. Based on a review of the Mealtime Coordinator, Feeding and Mealtime Management, and Nutrition Services training curricula, recommendations made in the previous report related to the need for instructional content to support the attainment of mealtime foundational knowledge and skills had been incorporated. This was a significant positive advancement in the provision of adequate MTC training to support safety at mealtimes. Another positive development was the utilization of a team of two staff, a residential representative and a mealtime content expert, to complete the MTCs' performance check-offs. In addition, the MIC committee members had developed instructions for the MTC performance check-off. This was helpful in supporting inter-rater agreement between the evaluators. The Facility should expand the MTC competency check-off to	

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		include the specific probes/indicators presented on the instruction sheet. For example, question number two on the check-off stated: "Infection control procedures are being followed throughout the meal." However, the instruction sheet asks the evaluator to refer to seven probes/indicators. The MTC competency check-off should reflect the probes on the instruction sheet to enable the evaluator to score specifically which infection control indicator the MTC did not follow if the indicator was scored no. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. Of note, however, was the significant progress the Facility made with regard to staff's adherence to dining plans. The Mealtime Improvement Committee should continue to complete competency performance check-offs for all Mealtime Coordinators, and revise the MTC Competency Check-off form to incorporate probes/indicators from the instructions. The Facility had not yet developed and implemented the mealtime monitoring database to provide an analysis of the data to determine the success of the mealtime safety initiative. The Director of HT and Unit Directors were just in the planning stages of developing and implementing a plan for the provision of PNM competency-based training and performance check-offs for veteran staff. In addition an area of continuing concern requiring concentrated efforts related to nurses' consistent and adequate implementation of PNMPs during medication administration.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> Based on interview with the Director of HT, the therapists had initiated a review of the New Employee Orientation curriculum in November 2011 to establish which PNM skills would require staff demonstration. This review produced the development of six PNM competency performance check-offs. This was a positive move forward in requiring new employees to complete performance check-offs to test their competency with learned skills. The requirement for new employees to complete performance check-offs during NEO would require additional time to be built into the NEO schedule for HT training. The HT Director and Competency Training and Development (CTD) Director met and agreed to expand the HT training schedule by one half day. This time expansion provided a total of three half-days to allow sufficient time for instruction and the completion of staff performance check-offs. The first one-half day training schedule presented the instruction for the PNMP, bracing, and positioning (i.e., duration of four hours); the second half-day agenda included instruction for alternative/augmentative communication (AAC) and orientation and mobility (i.e., duration of four and a half hours); and the third one-half day was devoted to mealtime assistance and feeding/mealtime management (duration of four hours). In January 2012, the revised training schedule was implemented, including staff performance check-offs. The new	Noncompliance

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		check-off demonstration tools implemented in NEO included: ▪ Mechanical lift (no passing criteria identified); ▪ Stand-pivot transfer (no passing criteria identified); and ▪ Two-person manual lift (no passing criteria identified). The preceding three check-offs required adequate staff demonstration. ▪ Positioning competencies (required 100% level of competency to pass). The check-off should require staff to demonstrate competency with wheelchair positioning and alternate positioning; and ▪ Mealtime check-off (required 80% level of competency to pass). This check-off should require staff demonstration of an individual's presentation techniques for food and fluid. In addition, there were three written tests, including: PNMP, Handling, and Positioning Quiz (score of 80% required to pass); Mealtime Assistance Test (no passing criteria identified); and New Employee AAC Competency Test (no passing criteria identified). Passing criteria should be established for demonstration check-offs and written tests. The Facility acknowledged that veteran staff would need to complete these core PNM competency performance check-offs. At the time of the review, the Director of HT was beginning the process of developing a training plan with Unit Managers. The Facility should implement PNM competency-based training and performance check-offs for veteran staff. <u>All foundational trainings are updated annually</u>. At the time of the review, therapists provided two annual refresher courses entitled: Lifting People and Preventing Aspiration. These courses were appropriate. However, the Facility should expand the annual refresher training to include instruction on mealtime safety. The LBSSLC Active Employee Course Participation Report, date range of 10/1/11 to 3/21/11, reported that 257 employees had completed Lifting People. The LBSSLC Course Participation Report, date range of 9/11 to 3/31/12, indicated that 13,033 employees had completed Preventing Aspiration." However, the number of staff completing Preventing Aspiration did not appear to be accurate. The presentation of data for staff completion of annual refresher training should include the total population of staff that must complete the training (N), and the sample of the population (n) which successfully completed the annual refresher training (n) to produce a compliance percentage score (n/N). <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> The therapists were to be commended for the development of individual-specific written and pictorial instructions for wheelchair and alternate positioning, transfers, and dining	

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		plans that provided additional instructions for staff. Many of the PNMPs for individuals in Sample O.3 included individual-specific staff instructions that would require staff to complete competency-based training and performance check-offs. Eight of the 10 Individuals' staff (80%) in Sample O.3 had completed training for individual-specific PNMP strategies. Individual #56 and Individual #281's records did not include documentation for staff training. It was positive that training was being provided to staff for changes to an individual's PNMP. The following observations were noted: ▪ Eight individuals within this sample had their PNMPs revised to the new format. Staff had completed one of three different written tests, including: PNMP Risk and Triggers, PNMP Change, and/or New PNMP Format. However, written tests without a demonstration component did not meet the standard of competency-based training for the required skills or competencies (i.e., Individual #16, Individual #324, Individual #78, Individual #104, Individual #323, Individual #128, and Individual #139); ▪ Individual #199's records noted staff performance check-offs for AAC/AT Equipment Competencies. However, staff had not completed performance checks-offs for his PNMP strategies to include bed elevation, wheelchair and alternate positioning, and assisted ambulation. ▪ Individuals had written and pictorial instructions developed for their wheelchairs and alternate positions (i.e., modified left and right sidelying, modified left sitting, bed elevation, modified left sidelying in recliner, supine position in bed and recliner) (i.e., Individual #104, Individual #56, Individual #323, Individual #16, Individual #281, Individual #324, Individual #139, Individual #128, Individual #78, and Individual #199). However, there was no evidence that staff had completed a performance check-off to test their competency in following these individual-specific instructions. <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> As discussed above, direct support professionals responsible for providing PNM supports to the individuals had not completed performance check-offs for individual-specific PNMPs and dining plans. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team. The Facility had not yet provided PNM competency-based training and performance check-offs to veteran staff for core PNM competencies and individual-specific competencies. In addition, the NEO competency check-offs for positioning and	

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		mealtimes did not yet ensure staff demonstrated positioning of an individual in optimal alignment and support in various alternate positions, as well as dining plan presentation techniques for food and fluid.	
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> The Facility provided the following monitoring forms: ▪ AAC Individual Equipment Monitoring Form, revised 2/3/12; ▪ HT Meal Observation, revised 12/29/10; ▪ HT PNMP Observation, revised 12/29/10; and ▪ Compliance Monitoring form, dated 2/14/12. Based on interview, monitoring results also were documented in an individual's Integrated Progress Notes. However, no Facility policies and/or procedures had been developed or implemented for these monitoring forms. As recommended in previous reports, the HT Department should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.); ▪ Training and validation process for monitors to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors requiring enhanced PNMP and mealtime monitoring; ▪ Formal schedule for monitoring to occur; ▪ Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement; ▪ Auditing process of completed monitoring forms to ensure compliance with Facility policy; ▪ Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and ▪ Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs and therapy programs. <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> Individuals at high risk of aspiration were at a heighted risk level during a variety of daily activities (e.g., wheelchair and alternate positioning, mealtimes, tooth brushing, bathing,	Noncompliance

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		medication administration, personal care, etc.). These individuals should receive enhanced monitoring to ensure staff compliance with dining plans and PNMPs. However, the Monitoring Team's review of the 16 individuals' records in Sample O.4 found: ▪ None of the 16 individuals' staff (0%) in Sample O.4 were monitored during mealtimes for individuals who ate orally and/or received enteral nourishment to assess staff compliance with dining plans. Individuals at high risk for aspiration should received enhanced monitoring during mealtimes. The Facility should define the frequency of monitoring for individuals at high risk for aspiration and related PNM risk indicators. The individuals' monitoring schedules should be defined in their risk action plan. ▪ Six of the 16 individuals' staff (38%) in Sample O.4 were monitored to assess their compliance with individuals' positioning. However, the monitoring frequency for these six individuals was not adequate. During the past six months, only positioning was monitored. Individual #176 was monitored nine times, Individual #323 three times, Individual #139 two times, and Individual #139, Individual #199, and Individual #78 were monitored one time. As stated above, the HT Department should develop procedures to ensure individuals with high PNM risk indicators receive enhanced monitoring. Based on interview with the Director of HT, in December 2011, a new Compliance Monitoring form had been implemented. The form had four observation indicators, including PNMP/Dining Plan was present/easily located; equipment was present, working, and utilized; plan was being performed as written/instructed; and staff communicated with individual before and during activities. Six indicators were for staff drills, including explaining the plan's rationale, goal(s), and outcome(s); explaining risk associated with not performing program; identifying individual triggers; whether or not staff reported being trained on the program; whether or not staff entered data correctly in appropriate location; and identifying who to contact, if there was a problem. The form could be utilized for individual-specific monitoring, random competency checks, and corrective action competency re-checks. The compliance threshold was 80% and above. If the compliance score was below 80%, a plan would be initiated, which could include notification of a Home Supervisor or Unit Director, follow-up meal observation, staff competency re-drill, and/or other plan to be identified on the form. For staff with a second non-compliance score, supervisory staff needed to complete program implementation monitoring. The form included a section for reliability checks to be completed by the PNMP Coordinator and therapist. Based on the Monitoring Team's review of the Compliance Monitoring form, the instructions for the four observation indicators identified multiple areas that the monitor would be responsible for checking for meals/snacks, medication administration, oral	

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		care, bathing, lifting/transferring, and communication. This information was to be monitored, however, related indicators were not present on the monitoring form itself. In the instructions, the staff drill indicators also listed multiple areas to monitor for compliance. This was relevant information and should be incorporated on the monitoring form. A monitor would be challenged to remember multiple compliance indicators for each of the four observation questions, as well as the drill indicators. If an indicator was marked "no," the monitor was to document noncompliance in the form's comment section. The one-page form did not provide sufficient space to address multiple areas of noncompliance. In addition, the form and instructions addressed the implementation of reliability checks to be conducted by therapists. While testing the monitor's competency with areas requiring assessment, the therapy content expert(s) will have to be diligent during the reliability checks to determine if the form's indicators require revision. The Facility should incorporate information from the instructions under the observation and staff drill sections. <u>All members of the PNM team conduct monitoring.</u> Although the Facility did not have an overall policy on monitoring PNMPs, the Facility PNMT Guideline(s) identified the following PNMT monitoring requirements: ▪ The PNMT action plan was to identify monitors, and monitoring schedule, including frequency of monitoring; ▪ The PNMT was to monitor and reassess the individual's health status until the individual was determined to be stable or at lower risk; ▪ Monitors were to observe and reassess the individual in a variety of settings to ensure the objectives were appropriate to effect positive change; ▪ Monitors were to perform monitoring as assigned; ▪ A process was to be in place to train monitors on expected responsibilities and outcomes; ▪ The PNMT was to review and analyze monitoring results; and ▪ An ongoing monitoring and review schedule was to be in place to ensure continued implementation and efficacy of plans for individuals who had been discharged from the PNMT. Individual-specific monitoring form documentation was reviewed for the four individuals on the PNMT caseload in Sample O.2.a. The following was found: ▪ Four of the four individual records (100%) included completed HT PNMP Observation and Compliance Monitoring forms, as well as IPNs that documented monitoring had been completed. However, the individuals' action plans did not adequately define the frequency of monitoring. In addition, there were no action steps developed to initiate an analysis of the monitoring results. The Facility's Self-Assessment indicated that it was not in compliance with this	

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		requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The Facility had not yet developed and implemented a monitoring policy and/or procedure for PNMPs and dining plans. A monitoring database had not been developed and implemented to allow tracking/trending of data to report staff compliance with safely and appropriately implementing PNMPs and dining plans.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> The Facility Self-Assessment noted that the PNMT was in the initial stages of developing a system to track and trend the progress of individuals with physical or nutritional difficulties. The Facility PNMT Guideline(s) should define the implementation of this monitoring system. The provision of data from this system should assist the Facility in collecting and analyzing data to monitor the progress of individuals with physical and/or nutritional difficulties. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> As discussed above with regard to Section O.6, no Facility procedure was in place to define the monitoring process for PNMPs and dining plans. Individual-specific monitoring documentation was reviewed for the 15 individuals in Sample O.1: ▪ Five of the 15 individuals' records (33%%) included documentation of monitoring to assess the effectiveness of individuals' PNMPs and dining plans. However, the frequency of monitoring was not adequate. The Facility did not have a policy to define the monitoring schedule for individuals who were at high risk for aspiration and/or had experienced a change in status. Individuals at high risk for aspiration should receive enhanced monitoring to confirm staff compliance with their risk action plans, PNMPs, and dining plans. Most importantly, ISPs and risk action plans did not include clinical risk indicators to assist teams in determining whether or not individuals were progressing, declining, or remaining stable. This is discussed in greater detail with regard to Section O.2, as well as Section I of the Settlement Agreement. In order to determine if plans were effective or if they needed to be revised, teams needed to develop and monitor such measurable objectives, and analyze the results. Teams then needed to take appropriate action as warranted by each individual's status. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The Facility Self-Assessment activities referred to the development of a	Noncompliance

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		monitoring system, including the use of a database. The implementation of a monitoring system would provide relevant data to substantiate the progress of individuals and the effectiveness of the risk action plans, PNMPs, and dining plans.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to by mouth (PO) status.</u> A total of 43 individuals (20% of total census) were enterally nourished. Currently, the Facility did not have a tracking system to identify the date an individual received a feeding tube. The DADS At-Risk Individuals policy, dated 11/2/10, required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition." The APEN assessment had an established format. The assessment was to be completed with input from the Primary Care Practitioner, RN, Habilitation Therapists, Dietician, Pharmacist, and other IDT members. The Nurse Case Manager was responsible for compiling information from other disciplines into the APEN assessment format. The APEN assessments should address the medical necessity for the continued use of a feeding tube, provide justification for the continued need to receive enteral nutrition, and/or address the individual's potential to transition to a less restrictive form of enteral nutrition, which might lead to the development of a plan to return an individual to oral eating. The APEN assessments for 10 individuals in Sample O.3 were reviewed. The following are the findings from this review: ▪ Five of the 10 individuals (50%) (i.e., Individual #323, Individual #104, Individual #139, Individual #324, and Individual #128) had an APEN assessment. Five individuals did not have an APEN assessment (i.e., Individual #16, Individual #56, Individual #199, Individual #281, and Individual #78). However, the following problematic concerns were noted for the five individuals with APEN assessments: o Measurable outcomes developed for these five individuals stated that they would not experience aspiration pneumonia. The primary focus of the assessments was related to the development of a plan to reduce the individuals' risk for aspiration pneumonia. However, the APEN assessment should also explore an individual's potential to transition to a less restrictive form of enteral nutrition, and/or assess the possibility of returning to oral intake, if appropriate. o APEN evaluations were not completed and/or updated prior to an individual's annual ISP meeting (i.e., Individual #139, Individual #104, Individual #323, and Individual #128). Individual #324's APEN assessment noted: "revised ISP date 2/9/12," but it was not clear what	Noncompliance

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		revisions had been made to the initial APEN assessment. The assessment did not have clinicians' signatures and dates that would have documented when the revisions had occurred. o Key sections were blank on individuals' APEN assessments. For example, pharmacological analysis of medications, analysis of findings, recommendations and action plan (i.e., Individual #128); no action plan for pleasure feedings (Individual #323 and Individual #128); and dental/oral health issues (Individual #324). ▪ None of the five individuals' APEN assessments (0%) indicated that there was input from appropriate IDT members as outlined in the APEN assessment format. The Facility should provide training to IDT members to understand the purpose of an APEN assessment. This process should go beyond the development of a plan to mitigate the risk of aspiration pneumonia. As the APEN format identified, the APEN assessment should be completed through a collaborative interdisciplinary assessment process. In addition, the Facility should develop and implement an APEN audit tool to assess compliance with the quality of APEN assessments. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> Based on interview with the HT Director, at the time of the review, no individual was at risk of receiving a feeding tube. The Facility PNMT Guideline(s) for referral to the PNMT noted: "The IDT and/or the PCP [primary care physician] may refer those individuals at high risk who are not stable and for whom the team needs assistance to develop a plan and/or for an assessment from [the] PNMT." The Facility PNMT guidelines should define the process for how the PNMT would be alerted when an individual is being considered for placement of a feeding tube. If an IDT did not make a referral to the PNMT, the PNMT should initiate a self-referral. <u>The need for continued enteral nutrition is integrated into the ISP.</u> Based on a review of the 11 individuals' ISPs in Sample O.3, none of the 11 individuals' ISPs (0%) documented the rationale for the continued need for enteral nutrition, transition to a less restrictive method of receiving nutrition, and/or attempts to return the individual to full or partial oral intake. <u>A policy exists that clearly defines the frequency and depth of assessments (Nursing, MD, SLP or OT).</u> No Facility protocols defined this process.	

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		<u>When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used.</u> The Facility noted that two individuals (i.e., Individual #323 and Individual #128) received pleasure foods and/or therapeutic feeding programs. A review of their records found: ▪ Individual 323's APEN evaluation, dated 3/15/11, indicated his IDT had agreed to begin pleasure feedings, which was a positive development. His APEN assessment ISPA, dated 2/16/11, and dining plan, dated 8/17/11, presented steps to be completed for the initiation and continuation of pleasure feedings. However, the APEN did not provide an action plan with measurable outcomes and recommendations to track the success of returning Individual #323 to oral eating. ▪ Individual #128's APEN assessment, dated 2/9/11, noted "partial PO [by mouth] are during lunch only with enteral feeding throughout the day." However, the APEN's assessment analysis of findings, recommendations, and action plan were blank. The measurable outcome was: "will not have any diagnosis of aspiration this next year." It was commendable that the Facility had transitioned these individuals to oral intake, but no plan was presented. This provision requires the "Facility shall implement a plan to return the individual to oral feeding." The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The Facility should develop protocols to define the purpose and content of APEN assessments to meet the intent of the Settlement Agreement for this section. Training should be provided on these procedures to assist IDT members in meeting the intent of an APEN assessment. The Facility should develop and implement an APEN assessment audit tool to assess compliance with the quality of an APEN assessment. As noted above with regard to Section O.1, the Facility should establish procedures for the IDT to alert the PNMT if an individual is at increased risk for receiving a feeding tube.	

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

1. A PT should participate in PNMT meetings on a regular basis. (Section O.1)
2. The following additions should be made to the PNMT Guideline(s):
    a. The guidelines should include a requirement for IDT members to refer individuals who are at risk of receiving a feeding tube to the PNMT; and
    b. Within the section of PNMT Roles at the Hospital, the Facility PNMT Guideline(s) should define the IDT and PNMT responsibilities for

individuals on their caseload who are hospitalized. The guidelines should reference the IDT and PNMT's responsibilities as noted in the State At-Risk Individuals policy for change of status. (Section O.1)

3. The PNMT should document the status on resolution of systemic concerns in the monthly meetings with the Facility Director. (Section O.1)
4. The Facility should implement training for IDT members on the Facility PNMT Guideline(s) to increase their understanding of the PNMT referral process. (Section O.1)
5. To support successful development and implementation of adequate and effective comprehensive PNMT assessments and action plans, the following is recommended:
    a. The PNMT should be more assertive in initiating self-referrals for individuals with multiple hospitalizations related to PNM issues.
    b. The PNMT assessment should include an adequate review of an individual's risk levels during the assessment process, and the risk ratings should be updated, as appropriate.
    c. PNMT assessments and action plans should be completed in alignment with the State's At-Risk policy timelines.
    d. The PNMT assessments should document a comprehensive review of an individual's PNMP to determine if staff strategies continue to be adequate to minimize risk factors.
    e. The PNMT assessment should define clinical indicators for the PNMT and nursing staff to monitor. These clinical indicators should define stable and unstable health status.
    f. The PNMT assessment and risk action plan should define the criteria for when nursing is to alert the PNMT to a health status change. These PNMT alert criteria should be integrated into nursing care plans.
    g. The PNMT Action Plans should be updated when an individual experiences a change in status, which would also include an emergency room visit, and/or hospital admission.
    h. The PNMT Action Plan should have an action step to track/trend individual-specific data to analyze the efficacy of action plan interventions and their success in mitigating an individual's risk factors.
    i. The PNMT action plan should be integrated into the ISP and in the plans developed by appropriate disciplines (e.g., Nursing Care Plans) (Section O.2)
6. To facilitate progress in addressing the requirements for Section O.2, the Director of HT should finalize and implement a PNMT auditing process to include PNMT assessments, action plans, and related documents to assess the quality of PNMT work products and determine if progress is being made. The audits should identify strengths and weakness with the PNMT process to enable the structured implementation of changes to move the PNMT forward toward compliance. (Section O.2)
7. The PNMT Nurse, in collaboration with Facility medical personnel, should establish guidelines to ensure the PNMT is immediately informed of an individual's related changes in status, including an emergency room, and/or hospitalization admissions. (Section O.2)
8. The Facility should define the PNM criteria for individuals who require a physical and nutritional management plan. Based on these criteria, the list of 48 individuals with "no PNM needs" should be reviewed to determine which of these individuals meet the PNM criteria, and as appropriate, they should be provided with an adequate PNMP to meet their needs. (Section O.3)
9. The Facility should develop guidelines to support consistency in the development of PNMPs. (Section O.3)
10. The Facility should continue the revision of individual PNMPs and dining plans campus-wide. (Section O.3)
11. The Facility should finalize and implement a PNMP audit tool to assess compliance with written PNMP procedures. (Section O.3)
12. The PNMT Discharge Plan should provide specific, detailed recommendations to the IDT to support an individual's stable health status. Specifically, the Discharge Plan should identify the detailed action steps that the IDT should continue to implement, and these action steps should be integrated into the ISP Risk Action Plan. (Section O.3)
13. The attendance of only one therapy professional at an annual ISP meeting should be reevaluated. (Section O.3)
14. Individuals discharged from the PNMT should be audited to ensure compliance with the Facility PNMT Guideline(s). (Section O.3)
15. A timeline should be developed and implemented for the completion of HOBE assessments for the identified universe of individuals who meet the criteria for a HOBE assessment. (Section O.3)

16. The Director of HT should collaborate with the Chief Nurse Executive to develop a plan for providing competency-based training and performance check-offs for the Facility nurses. The training should cover wheelchair and alternate positioning, mealtime presentation techniques, purpose and use of mealtime adaptive equipment, and diet textures and fluid consistencies. (Section O.4)
17. The performance check-offs for Positioning Competencies should require staff to demonstrate competency with alternate positioning, such as sidelying and modified supine. (Section O.5)
18. The Mealtime check-off should require staff demonstration of an individual's presentation techniques for food and fluid. (Section O.5)
19. The provision of competency-based training and staff performance check-offs for PNM core competencies for veteran staff should be implemented. (Section O.5)
20. The implementation of competency-based individual-specific training and performance check-offs for PNMP strategies and other related therapy programs should be initiated. (Section O.5)
21. As one measure of staff competency-based training compliance, data should include the total number of staff who will require training (N) and the number of staff who have completed PNM training (n) to yield a compliance percentage. This should be calculated for foundational training, annual refresher training, and individual-specific training. (Section O.5)
22. As recommended in previous reports, the Facility should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.);
    b. Training and validation process for monitors to achieve accurate scoring and a high level of inter-rater agreement.
    c. Identification of PNM risk factors which require enhanced PNMP and mealtime monitoring;
    d. Formal schedule for monitoring to occur;
    e. Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement;
    f. Auditing process of completed monitoring forms to ensure compliance with Facility policy;
    g. Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and
    h. Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs therapy programs. (Section O.6)
23. The Facility should develop and implement a system to analyze the results of the new Compliance Monitoring form. Part of this analysis should assess if the monitoring activities produce adequate data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. (Section O.6)
24. The Facility should finalize an audit tool for APEN assessments. The monitoring tool should include criteria that will accurately reflect the strengths and weaknesses in the quality of the APEN assessments. (Section O.8)
25. Training should be provided for IDT members required to provide discipline-specific clinical assessments and collaborate in the completion of an APEN assessment. (Section O.8)
26. The Facility should develop and implement the audit tools, databases, and systems identified in the Facility Self-Assessment for Sections O.1 through O.8. (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 LBSSLC Section P Presentation for Monitor's 4th Compliance Visit March 2012; o The following documents: Occupational Therapy (OT) and Physical Therapy (PT) consultations for the past year, Head of Bed Elevation (HOBE) assessment, Wheelchair assessment, Individual Support Plan and Individual Support Plan Addendums for the past year, Physical and Nutritional Management Plan with supporting pictures, Dining Plan, PNMP Clinic documentation for the past year, individual-specific monitoring, competency-based training for Physical Nutritional Management (PNM), Community Living Discharge Plan, Integrated Risk Rating Form, Risk Action Plan, and supporting documentation for implementation of OT/PT recommendations in Risk Action Plans for 19 individuals, including: Individual #156, Individual #164, Individual #280, Individual #235, Individual #26, Individual #322, Individual #213, Individual #78, Individual #309, Individual #198, Individual #298, Individual #80, Individual #116, Individual #104, Individual #167, Individual #90, Individual #55, Individual #14, and Individual #252; o OT/PT assessments for the following 23 individuals: Individual #114, Individual #225, Individual #62, and Individual #263, Individual #156, Individual #164, Individual #280, Individual #235, Individual #26, Individual #322, Individual #213, Individual #78, Individual #309, Individual #198, Individual #298, Individual #80, Individual #116, Individual #104, Individual #167, Individual #90, Individual #55, Individual #14, and Individual #252; o OT/PT assessments for the following two individuals who were newly admitted: Individual #57 and Individual #31; o Organizational Chart of Habilitation Therapy Department, including titles and names of staff holding management positions, undated; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, including contract staff, with titles, current caseloads, and license numbers, undated; o Continuing education completed by OTs and PTs, and assistants/technicians, since last onsite visit, various dates from 8/11 to 2/12; o List of individuals who use wheelchair as primary mobility, dated 2/13/12; o List of individuals with transport wheelchairs, dated 2/13/12; o List of individuals with other ambulation assistive devices, undated; o List of individuals with orthotics and/or braces, undated; o PNM maintenance log utilized by the Facility to track modifications made to individuals' adaptive/assistive equipment, from 1/11 through 1/12; o OT/PT evaluations and updated templates, undated; o OT/PT evaluations for individuals newly admitted to the Facility since the previous

	review, 11/11 through 1/12; o Tracking log of completed evaluations, from 7/11 through 2/12; o Wheelchair seating and PNM clinic assessment templates, undated; o Instructions for use related to wheelchair seating and PNM clinic assessments, revised 7/18/06; o OT/PT-related spreadsheets, dated 2/13/12; o Since last review, copy of blank monitoring form(s) that were used by OTs, COTAs, PTs, PTAs, and PNMP Coordinators, various dates from 12/10 to 2/12; o Copies of blank competency-based performance check-off sheets related to OT/PT and foundational/core competencies for physical and nutritional supports implemented since the last review, undated; o Examples of completed staff competency-based check-off sheets, multiple dates; and o Quality assurance reports and corresponding action plans related to OT/PT generated by Facility, from 8/11 through 2/12. ▪ **Interviews with**: o Linda Thomas, OT, Director of Habilitation Therapy (HT); o Megan Copeland, OT; o Tiffany Kubena, OT; o Jon Olive, PT; o Jennifer Cunningham, PT; and o Melissa Olive, PTA. ▪ **Observations of**: o Observations in the following residences, including dining rooms: 504 East Quail, 504 West Sparrow, 528 North Cedar Avenue Zinnia, 513 South Cedar Aspen, 536 Magnolia Boulevard Workshop, 524 North Cedar Avenue Lilly, 525 North Cedar Avenue Rose, 526 North Cedar Avenue Tulip, 514 South Cedar Avenue Birch, and 539 Lark Street Activity Center.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section P of the Settlement Agreement, the Facility found it was in noncompliance with the subsections of Section P. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: LBSSLC Self-Assessment, Action Plans, and Provision Action Information. The LBSSLC Self-Assessment listed the steps the Facility staff conducted to complete the self-assessment, and the subsequent results for the completion of these tasks. The LBSSLC Provision Action Information listed actions completed since the previous compliance visit. The Facility's Self-Assessment had begun to outline a set of data and auditing activities to assess its compliance with the Settlement Agreement. In addition, in a few cases, data had been collected and was reported in the Self-Assessment. These were positive initiatives. However, many of the systems the Facility intended to use had not yet been fully developed, and, as a result, data was not yet available. As the Facility finalizes its self-assessment procedures, it will be important to ensure that indicators reflect the

	quality of the supports and services, as well as their presence and timeliness. In addition, the Facility should ensure that the indicators are detailed enough to measure the various requirements of the Settlement Agreement. The data produced should be sufficient to assist the Facility in identifying areas in which progress has been made, and those still requiring improvement. The QA/QI Quarterly Summary for Section P for August, September, and October 2011 reported overall inter-rater reliability for August was 29%, and September 86%. However, no explanation was provided regarding how these reliability scores were determined. The QA/QI report did not indicate what the Facility did to remediate the August score of 29%, or discuss how the Facility achieved the score of 86% for September. The summary noted that HT Department monitoring was temporarily deferred in October, November, and December 2011, and January 2012 until additional therapists were hired.
	Summary of Monitor's Assessment: During the current review, the census for LBSSLC was 220 individuals. The Facility had five OT and three PT positions allocated, which was consistent with the numbers from the last review. At the time of the onsite review, the Habilitation Therapy Department had two OTs, one Certified Occupational Therapy Assistant, and three vacant OT positions. In addition, the facility had two PTs, one PT Assistant, and one vacant PT position. Based on interview and review of documentation provided by the Facility, the Director of Habilitation Therapy and the Job Requisition Coordinator continued to recruit therapists through newspaper ads, participation in job fairs, and working with contract staffing companies. On a positive note, Facility OTs, PTs, and a PTA attended a variety of State webinars and continuing education that were appropriate. Based on review of individuals' records, the Facility OTs and PTs had used three different formats for assessments: the OT/PT comprehensive assessment format, an OT/PT update, and an assessment of current status. The OT/PT assessment update format had been discontinued. The assessment of current status was to take the place of the OT/PT update format. Although in its response to the draft report, the State indicated no "comprehensive" assessment existed, the Facility provided an assessment template entitled: "Occupational/Physical Therapy – Comprehensive" as part of its response to document requests, and this template was included in individuals' records. The Director of HT was in the process of prioritizing individuals and developing a schedule for the completion of the assessment of current status. The key elements included in the OT/PT assessment of current status format were high and medium risk levels, PNMP risk analysis review, other services/supports, consults, eating/dining/swallowing, assistive equipment, recommendations, measurable outcomes, and factors in community placement. However, the assessment format did not provide content guidelines to define what information should be included under each of these headings. No Facility policies and/or procedures were available for the completion of the two OT/PT assessment formats. In addition, the two assessment formats did not provide guidelines and/or required content under specific assessment sections. Documentation submitted showed that none of the 220 individuals (0%) living at LBSSLC received direct OT and/or PT service programs. At the time of the review, the primary therapy intervention provided for individuals was a PNMP and a dining plan.

	A review of individuals' records noted that some individuals' PNMPs were not current, OTs and PTs did not consistently attend an individual's annual ISP meeting, ISPA meetings were not convened to discuss PNMP changes, and PNMP strategies were not integrated into ISPs within risk action plans, nursing care plans, skill acquisition programs and/or Positive Behavior Support Plans. The Provision Action Information indicated HT therapists reviewed the New Employee Orientation (NEO) curriculum in November 2011, and identified the need for staff check-off demonstrations. This resulted in the development and implementation of performance check-offs to test staff competency with core PNM competencies. This initiative was a positive development that required new employees to demonstrate competency with skills presented in orientation. The HT Director and Competency Training and Development (CTD) Director agreed to expand the HT training schedule an additional one-half day to allow sufficient time for instruction and the completion of staff performance check-offs. In January 2012, the new check-off demonstration tools were implemented in NEO. However, no compliance data was reported for the number of new employees that completed NEO performance check-offs (N) and the number of employees (n) who had passed. The Director of HT acknowledged that veteran staff would also need to complete competency performance check-offs for core PNM competencies. The HT Department did not have a policy and/or procedure to define the requirements for the completion of an OT/PT assessment of prescribed PNMP adaptive/assistive equipment to address fit, availability, function, condition, and effectiveness of the equipment. Individuals' records reviewed did not indicate an assessment of their prescribed adaptive/assistive equipment had been completed. Furthermore, individuals' adaptive/assistive equipment was not monitored on an established schedule for availability, condition and use of adaptive/assistive equipment. Based on interview with the Director of HT, she had approved the use of a new Compliance Monitoring form. In December 2011, the therapists initiated the use of the Compliance Monitoring tool. The tool was designed to monitor staff compliance with positioning, meals, snacks, medication administration, oral care, bathing, lifting/transfers, and communication. Copies of the monitoring forms were being provided to the Residential Coordinator and Unit Manager for their review. It was noted that a meeting would be scheduled to discuss action plans and a tracking system to ensure closure for identified issues. At the time of the onsite review, this meeting had not occurred. The Director of HT stated that Compliance Monitoring tool data was being entered into a database. However, no analysis of the Compliance Monitoring form data had been initiated.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of	The Monitoring Team's samples of individuals for Section P included: ▪ Sample P.1 includes 23 individuals of 220 individuals (total census) who had received an OT/PT comprehensive assessment, OT/PT update, and/or OT/PT assessment of current status, including: Individual #156, Individual #164, Individual #280, Individual #235, Individual #26, Individual #322, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	#213, Individual #78, Individual #309, Individual #198, Individual #298, Individual #80, Individual #116, Individual #104, Individual #167, Individual #90, Individual #55, Individual #14, Individual #252, Individual #114, Individual #225, Individual #62, and Individual #263. ▪ Sample P.2 includes two of three individuals who were newly admitted to LBSSLC including: Individual #57 and Individual #31; ▪ Sample P.3 includes 19 individuals of 220 (total census) individuals' who had experienced a change in status and/or had a PNMP including: Individual #156, Individual #164, Individual #280, Individual #235, Individual #26, Individual #322, Individual #213, Individual #78, Individual #309, Individual #198, Individual #298, Individual #80, Individual #116, Individual #104, Individual #167, Individual #90, Individual #55, Individual #14, and Individual #252. In assessing its progress for Section P.1, LBSSLC indicated that since the last review, the following steps were initiated related to this requirement of the Settlement Agreement: ▪ A Facility spreadsheet was reviewed to determine the progress on the completion of OT/PT assessments. The self-assessment results indicated 41 OT/PT assessments had been completed. However, it was unclear how many OT/PT assessments were required to be completed within this time period. There were no defined parameters to indicate if the completion of 41 assessments was a positive or negative result. In addition, no indication was provided regarding whether or not the assessments were audited for quality and the presence of key elements required for assessment. ▪ An assessment log for individuals who were newly admitted was reviewed to evaluate if the OT/PT comprehensive assessments included key elements and had been completed within 30 days of admission. A review from October 2011 to February 2012 indicated two of two (100%) OT/PT comprehensive assessments had been completed. However, no data was reported indicating if the assessments had been timely and contained the required assessment elements. ▪ In the section on "Activities engaged in to conduct the self-assessment," the Facility listed an audit of OT/PT assessments to evaluate compliance regarding identified key elements in the assessments. However, the self-assessment results stated that no data was reviewed, because the audit tool only recently had been developed and had not been implemented. ▪ The Facility Self-Assessment identified a review of the consultation tracking log as an activity to assess if therapists were documenting an individual's change in status. However, the Facility self assessment results noted that no data was available due to the system being "under development." Each provision topic/heading is underlined, and the narrative that follows summarizes	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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the Monitoring Team's findings.

<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u>
During the current review, the census for LBSSLC was 220 individuals. The Facility had five OT and three PT positions allocated, which was consistent with the numbers from the last review. At the time of the onsite review, the Habilitation Therapy Department had two OTs, one COTA, and three vacant OT positions. In addition, the Facility had two PTs, one PTA, and one vacant PT position. Based on the documentation provided, the following chart represents the caseload of the Facility OTs, PTs, and a PTA, including current therapy vacancies:

<table>
<tr><th>Occupational Therapist</th><th>Current Caseload</th></tr>
<tr><td>Director of Habilitation Therapy, OT</td><td>Director of Habilitation Therapies, PNMT member, and supported 41 individuals in residences 504 West, 504 East, and 517</td></tr>
<tr><td>OT #1</td><td>Supported 180 individuals in residences 513, 514, 515, 516, 517, 518, 520, 521, 523, 525, 526, 527, and 528</td></tr>
<tr><td>OT #2</td><td>Began employment 2/16/12, but had not been assigned a caseload</td></tr>
<tr><td>OT #3</td><td>Position vacant</td></tr>
<tr><td>OT #4</td><td>Position vacant</td></tr>
<tr><td>OT #5</td><td>Position vacant</td></tr>
<tr><td>COTA #1</td><td>No caseload assigned</td></tr>
<tr><th>Physical Therapist</th><th>Current Caseload and Responsibilities</th></tr>
<tr><td>PT #1</td><td>Supported 107 individuals in 514, 515, 516, 518, 520, 523, 526, 504 East, and 504 West</td></tr>
<tr><td>PT #2</td><td>Supported 114 individuals in residences 513, 517, 521, 525, 527, 528, 504West, and 504 East</td></tr>
<tr><td>PT #3</td><td>Vacant</td></tr>
<tr><td>PTA #1</td><td>PNMT member and supported 34 individuals in 504 East and 504 West</td></tr>
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Based on interview and review of documentation the Facility provided, the Director of Habilitation Therapy and the Job Requisition Coordinator continued to recruit therapists through newspaper ads, participation in job fairs, and working with contract staffing companies. The Facility Job Requisition Coordinator and Director of HT should continue to implement recruiting activities in attempts to fill the vacant OT and PT positions.
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#	Provision	Assessment of Status	Compliance
		<u>Continuing Education</u> Attendance sheets and continuing education certificates of completion were submitted for the courses completed since the last onsite review. Review of this documentation for OTs, PTs, and one PTA found the following: ▪ The Director of HT, OT #1, PT#1, PT#2, and a PTA attended the Issues in Evaluation and Treatment of Individuals with Developmental Disabilities at the Texas Annual Habilitation Therapy Conference, where multiple continuing education courses were presented; ▪ The Director of HT, OT#1, PT #1, and PT #2 completed a webinar entitled Winning Strategies for Malnutrition in Older Adults: From Identification to Intervention; ▪ The Director of HT, PT #1, and PT#2 attended a webinar for Core Training Dietary; ▪ OT #1 attended the webinar for PNMT training; ▪ The Director of HT, OT #1, PT#1, PT#2, and a PTA completed the Power of Access Introduction; ▪ OT #1 and a PTA attended a Breathing, Digestion and Swallowing: Best Practices in Dysphagia Management course; ▪ The Director of HT and a PTA completed Suction Tooth Brushing; ▪ The Director of HT completed the webinar for Altered GI Anatomy and Function and the New Americans with Disabilities Act Requirements; ▪ PT #1 attended a presentation for the Most Integrated Setting Information; ▪ OT #1, PT#2, and a PTA completed the Food Addictions, Overeating and Mood Swings course; ▪ The Director of HT attended Parkinson's Disease: Update from the Expert; ▪ The Director of HT, OT#1, PT #2, and PTA attended the ConvaTec Skin Cleanser Protocol and Supplies presentation; ▪ The PTA attended A Good Defense is a Strong Offense: New Insights in Immune Modulating Nutrition and Tools for Success – Dietetic Association; and ▪ Understandably, no continuing education documentation was submitted for OT #2 who recently began employment in February 2012. The Director of HT, OTs, PTs, and the PTA attended appropriate continuing education courses and State-sponsored webinars. <u>All individuals have received an OT/PT screening/assessment. If newly admitted, this occurred within 30 days of admission.</u> Based on information the Facility provided, two individuals had been admitted to the Facility since the last review. The Monitoring Team reviewed both of the newly admitted individuals' OT/PT assessments in Sample P.2 and found:	

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		▪ Two of the two newly admitted individuals (100%) had received a timely OT/PT assessment within 30 days of admission. ▪ None of the two newly admitted individuals (0%) had received an adequate assessment as described below: o The assessments indicated the IDT had not determined risk ratings and no further information was provided related to an individual's risk factors. The assessments did not address an individual's medium or high-risk areas that might require services and supports from an OT and/or PT. IDT members were responsible for completing a risk assessment to determine areas of risk within 30 days of an individual's admission to the Facility. The OT/PT assessment for individuals newly admitted should describe the services and supports to be provided to mitigate risk, provide rationale(s) for these services and supports, and identify individual-specific triggers that will alert staff to a change in status. The OT/PT assessment should provide sufficient clinical data to assist the IDT members in the completion of an individual's Integrated Risk Rating Form, and the subsequent development of the Risk Action Plan(s). o The assessments did not present an individual's medical history that should include: "procedures, surgeries, fractures, and/or medical conditions that could influence testing results or recommendations, including specialized evaluations, previous testing, and sensory impairments," as defined in the State-established OT/PT assessment format. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> Based on review of individuals' records, the Facility OTs and PTs had used three different formats for assessments. These included: the OT/PT comprehensive assessment format, an OT/PT update, and an assessment of current status. However, at the time of the review, the OT/PT assessment update format had been discontinued. Based on interview, the OT/PT assessment of current status was to take the place of the OT/PT update format. Although in its response to the draft report, the State indicated no "comprehensive" assessment existed, the Facility provided an assessment template entitled: "Occupational/Physical Therapy – Comprehensive" as part of its response to document requests (i.e., TX-LB-1203-XIII.7), and this template was included in individuals' records. The Facility's OT/PT comprehensive assessment format did not incorporate the content guidelines under each of the headings as were included in the State-established OT/PT assessment format. As a result, it was difficult to discern if the Facility OT/PT	

#	Provision	Assessment of Status	Compliance
		comprehensive assessment format required therapists to assess the content under each of the headings in the State-established OT/PT format. A review of individuals' assessments did not show that therapists were following the content guidelines in the State-established OT/PT format. An OT/PT update format was not submitted in the document request. However, multiple individuals in Sample P.1 received an OT/PT update. The key elements of the OT/PT update format headings included: active problems, medications, communication, range of motion, hand assessment, gait/mobility/transfers, foot assessment, posture, activities of daily living, nutritional management, oral motor/feeding, PT/OT consults, PNMP focus and review, strengths, and recommendations. Although these were important elements, some important components were missing from the format. The update format did not address an assessment of risk levels, assistive equipment, analysis of findings to provide a rationale for recommendations, measurable outcomes, monitoring schedule, and/or factors for community placement. The Director of HT was in the process of prioritizing individuals and developing a schedule for the completion of the assessment of current status. The key elements in the OT/PT assessment of current status format included: high and medium risk levels, PNMP risk analysis review, other services/supports, consults, eating/dining/swallowing, assistive equipment, recommendations, measurable outcomes and factors in community placement. The format included important elements, but content guidelines should be added to define what information should be assessed under each heading. No Facility policies and/or procedures defined the completion of these two OT/PT assessment formats. In addition, the two assessment formats did not provide guidelines and/or required content under specific assessment sections. For example, the Facility OT/PT comprehensive assessment had a header for diagnosis/medical history, but did not provide any content guidelines. The State-established OT/PT assessment format indicated: "diagnoses and active problems should be pertinent to Habilitation Therapies services and supports and should state the effect of the condition of the individual's health or function." In the State Office version, additional content was defined under medical history. The HT Department should integrate the State-established OT/PT assessment guideline content into the Facility OT/PT assessment formats to support a consistent approach to the completion of OT/PT assessments. The individuals in Sample P.1 had a completed OT/PT comprehensive assessment, update, or assessment of current status. An OT and PT working together completed all of these assessments (100%). A review of 23 individuals' OT/PT assessments in Sample P. 1 found:	

#	Provision	Assessment of Status	Compliance
		▪ Four of the 23 individuals had an OT/PT comprehensive assessment (i.e., Individual #167, Individual #104, Individual #78, and Individual #116). The following was noted: o Two of four assessments (50%) (i.e., Individual #78 and Individual #116) were dated as having been completed prior to the annual ISP. Assessment results should be provided prior to the annual ISP to assist IDT members in the making informed decisions in the development of skill acquisition programs and risk action plans. o The assessments followed the headings on the Facility OT/PT comprehensive assessment format. However, no content guidelines were provided in the Facility OT/PT assessment format. Consequently, the content in individual's assessment was not consistent from assessment to assessment. The Facility should integrate content guidelines from the State-established OT/PT assessment format. Based on interview, the Director of HT was in the process of finalizing an audit/monitoring tool. The audit indicators should incorporate these content guidelines to support consistency in the completion of assessments. o Three of these four assessments (75%) were signed and dated by the OT and PT. The PT did not date the assessment for Individual #104. o Four of the four assessments recommended skill acquisition programs (SAPs) for individuals with potential for skill development. However, these recommendations for SAPs were not integrated into the assessment recommendations. For example, a recommendation for a SAP for Individual #104 was indicated under Activities of Daily Living skills, but was not included in the assessment recommendations. ▪ Sixteen of the 23 individuals had an OT/PT update (i.e., Individual #225, Individual #164, Individual #114, Individual #62, Individual #280, Individual #235, Individual #252, Individual #322, Individual #213, Individual #309, Individual #80, Individual #298, Individual #156, Individual #26, Individual #14, and Individual #263). The following was noted: o Twelve of the 16 individuals' assessments (75%) (i.e., Individual #252, Individual #309, Individual #322, Individual #80, Individual #213, Individual #298, Individual #280, Individual #235, Individual #225, Individual #164, Individual #114, and Individual #62) were dated as completed prior to the annual ISP. o Sixteen of the 16 individuals' assessments (100%) were signed and dated by the OT and PT. o One of the 16 individuals' OT/PT updates (6%) adequately addressed their medium and high-risk levels (i.e., Individual #62). The remaining updates did not adequately address an individual's risk levels requiring	

#	Provision	Assessment of Status	Compliance
		supports from OTs and PTs. The updates did not describe how services and supports would mitigate risks, provide rationales for services and supports, discuss the efficacy of the interventions, and/or present individual-specific triggers that would alert staff to a change in status. o Four of the 16 assessments (25%) recommended skill acquisition programs for individuals identified as having potentials for skill development (i.e., Individual #298, Individual #80, Individual #309, and Individual #26). However, there were individuals' OT/PT assessments within this sample that noted individual deficits in activities of daily living (i.e., Individual #164, Individual #14, Individual #114, and Individual #252), mealtime safety skills (i.e., Individuals #235, and Individual #322), active HT treatment on mat (i.e., Individual #280), but no recommendations were made for SAPs. OTs and PTs should provide their clinical expertise to IDT members through recommendations for SAPs and by providing assistance to IDT members in the development of SAPs. ▪ Three of the 23 individuals had an assessment of current status (i.e., Individual #55, Individual #90, and Individual #198). o Three of the three individuals' assessments of current status (100%) were dated as completed prior to the annual ISP. o Three of the three individuals' assessments (100%) were signed and dated by the OT and PT. o None of the three individuals' assessment of current status was adequate in addressing an individual's risk levels. The updates did not describe how services and supports would mitigate risks, provide rationales for services and supports, discuss the efficacy of the interventions, and/or present individual-specific triggers that would alert staff to a change in status. ▪ A subset of 17 individuals who used a wheelchair in Sample P.1 (i.e., Individual #167, Individual #55, Individual #90, Individual #62, Individual #298, Individual #309, Individual #322, Individual #14, Individual #114, Individual #263, Individual #225, Individual #252, Individual #80, Individual #164, Individual #104, Individual #78, and Individual #280) found: o Seventeen of these 17 individuals' OT/PT assessments (100%) included an assessment of their seating system. The assessment content included a seating system goal, the appropriateness of their current seating system, and clinical impressions. The following problematic findings were noted in the review of individuals' OT/PT comprehensive assessments, updates, and/or assessment of current status:	

#	Provision	Assessment of Status	Compliance
		▪ As noted above, the Facility OT/PT comprehensive assessment format should incorporate the State-established content guidelines for each assessment heading to provide consistency in the content of individuals' assessments. ▪ Head of bed elevation (HOBE) assessments were not completed for a subset of 10 individuals (i.e., Individual #309, Individual #114, Individual #55, Individual #225, Individual #263, Individual #78, Individual #298, Individual #104, Individual #167, and Individual #62) in Sample P.1 who were at high risk for aspiration and/or respiratory concerns. The HOBE assessment should be completed to determine maximum and minimum elevation ranges for daily activities to mitigate an individual's risk factors. ▪ A comparative analysis of an individual's functional status from last year to the present assessment year was not included in the assessments. The Provision Action Information, updated 2/27/12, document noted that a review of the OT/PT assessments had been completed. The Facility reported assessments were individual-specific; included an evaluation of all therapeutic adaptive assistive devices for fit, function, effectiveness, and availability; included risk recommendations with rationale; addressed recommendations for skill acquisition programs, as appropriate; and included recommendations for supports for community placement. However, no further explanation was provided as to how many OT/PT assessments were reviewed, specifically what was reviewed, or how the findings were determined. Based on an interview with the Director of HT, an audit tool was being developed to audit the OT/PT assessments, which was a positive development. However, the audit tool was not provided to the Monitoring Team. The Director of HT should conduct routine audits to assess compliance with adequate completion of OT/PT assessments. The audit should not only assess compliance with format, but also should include a quality review of the assessment content. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u> Currently, no individuals were receiving direct OT and/or PT therapy. At the time of the review, the primary therapy intervention provided for individuals was a PNMP and a dining plan. A review of a subset of six individuals in Sample P.3, who had experienced a change in status (i.e., Individual #156 – choking, Individual #164 – fracture, Individual #280 – recurrent vomiting, Individual #26 – unplanned weight loss, Individual #213 – fracture, and Individual #78 – skin breakdown), found: ▪ None of the six (0%) individuals who had experienced a change in status had received a timely and adequate consultation and/or assessment to address	

#	Provision	Assessment of Status	Compliance
		their change in status. Individuals who experience a change in status should receive a re-assessment of their risk level(s), as well an assessment of the adequacy of their services and supports related to the health status change. This had not occurred for these individuals. A review of individual records found: o Individual #26 had lost 27 pounds from June to December 2012, but no consultation and/or assessment of status had been completed to address his weight loss. o Individual #280 had been hospitalized twice for recurrent vomiting, but no assessment had been completed to review his positioning during daily activities and/or mealtimes. o On 11/29/11, Individual #213 was hospitalized with a fracture, but the first consultation to address his non-weight bearing status was dated 2/21/12. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The quality of OT/PT assessments remained problematic. Efforts also were necessary to ensure that assessments were completed prior to individuals' annual ISP meetings. In addition, for individuals with a change in status, both the timeliness and quality of the reassessments were in need of attention.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment;	In assessing its progress for Section P.2, the Facility indicated that since the last review, the following self-assessment activities were initiated related to this requirement of the Settlement Agreement: ▪ A review of ISPs and ISPAs was to be completed to evaluate the integration of OT/PT recommendations in skill acquisition programs, and to determine if individuals' PNMPs had been developed with input from IDT members. However, the Facility self-assessment results noted there was no data to review, because this process was in the "developmental stages." ▪ PNMPs were audited to evaluate the presence of identified key elements. A review from October 2011 to February 2011 indicated 32 of 32 PNMPs (100%) had identified key elements. However, there was no discussion of how the sample of 32 PNMPs was selected. In addition, the results did not address the use of a PNMP monitoring tool with indicators to assess the compliance with presence of PNMP key indicators. ▪ The PNMP tracking log was to be reviewed to evaluate if changes were implemented and met individuals' needs as a result of a status change. However, the self-assessment results indicated no data was reviewed, because the system was in the "developmental stages."	Noncompliance

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	and, for individuals who have regressed, interventions to minimize further regression.	Within 30 days of the annual ISP, or sooner as required for health or safety, a plan has been developed as part of the ISP. Within 30 days of development of the plan, it is implemented. Documentation submitted noted that none of the 220 individuals living at LBSSLC (0%) received direct OT and/or PT service programs. Two individuals in Sample P.3 did not have PNMPs (i.e., Individual #26 and Individual #198). A review of a subset of 17 individuals' PNMPs in Sample P.3 found: ▪ Twelve of 17 individuals' PNMPs (71%) (i.e., Individual #164, Individual #104, Individual #167, Individual #90, Individual #309, Individual #55, Individual #156, Individual #298, Individual #80, Individual #235, Individual #78, and Individual #213) were current within the last 12 months. PNMPs for Individual #116, Individual #14, Individual 252 and Individual #280 were not current. An ISP was not submitted for Individual #322, and, as a result, it could not be determined if his PNMP was current. ▪ The OTs for eight of 17 individuals (47%) (i.e., Individual #167, Individual #55, Individual #298, Individual #213, Individual #235, Individual #104, Individual #80, and Individual #78) attended the annual ISP meeting. ▪ The PTs for six of 17 individuals (35%) (i.e., Individual #90, Individual #309, Individual #116, Individual #80, Individual #298, and Individual #164) attended the annual ISP meeting to discuss individuals' PNMP strategies. Appropriate intervention plans are: integrated into the ISP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. A review of the annual ISPs and ISPAs for a subset of 17 individuals in Sample P.3 found: ▪ None of 17 individuals' PNMPs (0%) were adequately integrated into their ISPs. Evidence was not found in individuals' ISPs of integration of PNMP strategies into action plans, nursing care plans, or, as appropriate, skill acquisition programs, and/or Positive Behavior Support Plans. ▪ None of a subset of eight individuals' PNMPs (0%), which were revised after the annual ISP meeting, had a subsequent ISPA meeting to discuss recommended changes in their PNMPs (i.e., Individual #164, Individual #167, Individual #156, Individual #80, Individual #298, Individual #235, Individual #78, and Individual #213). On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. During the last review, 13 individuals received direct therapy. However, at the time of the most recent review, no individuals received direct therapy. As a result, the	

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		Monitoring Team was not able to review the monthly submission of progress notes. The provision of direct therapy had been impacted by the resignation of OTs and PTs, which was problematic. As noted above, an OT recently had been hired. The Director of HT in collaboration with the OTs and PTs should explore ways to assist the therapists in having time to provide direct therapy to individuals. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
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.	In assessing its progress for Section P.3, LBSSLC indicated that since the last review, the following self-assessment steps were initiated related to this requirement of the Settlement Agreement: ▪ The Facility therapists reviewed the content of competency-based training for new employees to determine if necessary components were included. The self-assessment results stated competency-based training components were in place, and it was determined that veteran staff would need this training. Based on interview and the review of documentation, this review led to an expansion of time for HT training in NEO, as well as the development and implementation of performance check-offs for new employees. The Monitoring Team agrees that veteran staff should also complete these PNM core competency check-offs. ▪ A tracking log was to be reviewed to evaluate if results indicated the level of staff competency in implementing plans met or exceeded 80%. The self-assessment results indicated that no data was available for review, because the system "still needs to be developed." ▪ The monitoring database was to be reviewed to determine if actions were taken to resolve and bring closure to identified issues. The results indicated no data was available to review, because the "system was in the developmental stages." <u>Staff implements direct/indirect therapy plans identified by OT/PT.</u> The Monitoring Team's observations identified staff non-compliance with PNMPs and dining plans. This is discussed in further detail with regard to Section O.4. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT direct/indirect therapy plans.</u> The Provision Action Information noted that in November 2011, HT therapists reviewed the NEO curriculum to identify the need for the development of staff competency-based demonstration check-offs. This review produced the development of performance check-offs. This was a positive step forward in requiring new employees to complete performance check-offs to test their competency with skills taught in NEO. Based on	Noncompliance

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		interview with the Director of HT, the initiation of performance check-offs for new employees required an expansion of instructional time. The HT Director and CTD Director met and agreed to expand the training by one half day. This time expansion provided a total of three half-days to allow sufficient time for instruction and the completion of staff performance check-offs. In January 2012, the revised schedule was implemented. The first one-half day training schedule presented the instruction for the PNMP, bracing, and positioning (i.e., duration of four hours); the second half-day agenda included instruction for alternative/augmentative communication (AAC), and orientation and mobility (i.e., duration of four and a half hours); and the third one-half day was devoted to mealtime assistance and feeding/mealtime management (duration of four hours). The new check-off demonstration tools implemented in NEO included: ▪ The mechanical lift performance check-off listed the tasks staff were required to demonstrate in preparation for the lift, positioning required before the lift, and lift transfer techniques. The staff performance check-off was adequate to test staff competency. However, no passing criteria were identified. ▪ The stand-pivot transfer assessment checklist was adequate to test staff competency. However, the assessment checklist did not identify the passing criteria. ▪ The two-person manual lift assessment checklist was adequate to test staff competency. There were no passing criteria identified. ▪ The positioning competencies required 100% level of competency to pass. However, this form should be expanded to test staff competency for additional alternate positions, such as sidelying. ▪ The mealtime check-off required 80% level of competency to pass. This check-off step number seven required staff to "verbalize" what they would do to assist a person. This step should be modified to require staff to demonstrate mealtime presentation techniques. In addition, there were three written tests: ▪ PNMP, Handling and Positioning Quiz – score of 80% required to pass; ▪ Mealtime Assistance Test – no passing criteria identified; and ▪ New Employee AAC Competency Test – no passing criteria identified. No compliance data was reported for the number of new employees who completed NEO performance check-offs (N) and the number of employees (n) who had passed. A review of individuals' records in Sample P.3 for staff completion of competency-based training and performance check-offs found: ▪ None of the 19 individuals' records reviewed (0%) provided documentation of staff successfully completing competency-based performance check-offs for core PNM competencies.	

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		▪ None of 19 individuals' records reviewed (0%) provided documentation of staff successfully completing competency-based performance check-offs of individual-specific PNMP strategies. Six individuals' records (i.e., Individual #78, Individual #164, Individual #104, Individual #167, Individual #322, and Individual #116) included a written test for a PNMP change(s) and/or a new PNMP. However, no documentation was provided of staff completing a performance check-off. However, it should be noted that the Director of HT acknowledged that veteran staff would need to complete competency-based training and performance check-offs for core PNM competencies, as well as individual-specific PNMP strategies. At the time of the review, the Director of HT was working with Unit Directors to finalize a plan to provide this training to veteran staff. The Monitoring Team discusses the written tests in further detail with regard to Section O.6. The HT Department should produce data in the future to document compliance with staff completion of competency-based training and performance check-offs for core PNM competencies and individual-specific strategies for PNMPs, dining plans and OT/PT programs. The data should identify the number of staff to be trained (N) and the number of staff who have successfully completed a performance check-off. This compliance data should be provided for staff completion of core PNM competencies, PNMP individual-specific strategies, and OT/PT programs beyond a PNMP. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. It was positive that beginning in January 2012, NEO was expanded to include three one-half days of instruction, and included time for the completion of performance check-offs. However, competency-based training and performance check-offs for core PNM competencies for veteran staff had not been implemented. The Facility's finding with regard to noncompliance with this provision was consistent with the Monitoring Team's findings.	
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	In assessing its progress for Section P.4, LBSSLC indicated that since the last review, the following self-assessment activities were initiated related to this requirement of the Settlement Agreement: ▪ A review of monitoring forms was to be completed to evaluate staff competency and compliance related to the implementation of individuals' PNMPs. The tracking and trending of monitoring data would be a positive move forward, because it would provide data related to the implementation of individual's PNMPs, but most importantly, track resolution of identified individual-specific and/or systemic concerns. However, the self-assessment results indicated no data was available to review, because the review process	Noncompliance

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	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.	was "still under development." ▪ A monitoring tracking log was to be reviewed to evaluate monitors' compliance with their assigned schedule, completion of required documentation, and timely submission of completed forms. The self-assessment results indicated no data was available to review, because the system was being "developed and implemented." This also would be a positive addition. ▪ The consultation tracking log was to be reviewed to evaluate therapists' compliance with documentation of an individual's change of status. Self-assessment results noted no data was available, because the system was "still under development." The Director of HT should ensure the audit tool looks beyond the review of a tracking log. The audit tool should evaluate the quality of the assessment to determine if adequate services and supports are being provided to the individual as a result of the change in status. Consequently, none of these self-assessment steps had been implemented, because the systems were under development. The Facility is encouraged to develop these important self-assessment activities to assist in identifying areas in which progress has been made, as well as areas that still require attention. <u>System exists to routinely evaluate: fit, availability, function, condition, and effectiveness of all adaptive equipment/assistive technology.</u> The Provision Action Information noted that during the completion of an individual's OT/PT assessment, all therapeutic adaptive/assistive equipment was being evaluated for fit, function, effectiveness, and availability. Furthermore, the adaptive/assistive equipment assessment data was to be documented in the assessment's risk recommendations with a rationale provided, as appropriate. However, the OT/PT format for the comprehensive assessment and the assessment of current status provided a heading for adaptive/assistive equipment. However, the assessment formats did not define the guidelines for implementation of an adaptive/assistive equipment assessment. A review of the OT/PT assessments and/or PNMP clinic documentation for an assessment of prescribed adaptive/assistive equipment for 19 individuals in Sample P.3 found: ▪ Nineteen of the 19 individuals' OT/PT assessments and/or PNMP clinic documentation (100%) included an assessment of the individual's wheelchair. ▪ None of the 19 individuals' OT/PT assessments and/or PNMP clinic documentation (0%) included an adequate assessment of other prescribed equipment. The OT/PT assessment listed the individual's assistive equipment. However, the assessment did not specifically address the fit, availability, function, condition, and effectiveness of an individual's other assistive	

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		equipment. The OT/PT assessment should assess the fit, availability, function, condition and effectiveness of the equipment for all PNMP and dining plan prescribed equipment. The status of the review of communication assistive equipment is discussed with regard to Section R. ▪ None of the 19 individuals' prescribed adaptive/assistive equipment was monitored, at a minimum, on a monthly basis. Routine monitoring to address the status of individual's assistive/adaptive equipment had not been implemented. <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> Systemic issues related to monitoring are discussed with regard to Section O.6 of the Settlement Agreement. The HT Department did not have a policy and/or procedure to define the requirements for completion of an assessment of prescribed PNMP adaptive/assistive equipment. A policy or protocols should be developed to define the system for review of PNMP and dining plan prescribed adaptive/assistive equipment and should include the following: ▪ Definition in the OT/PT assessment formats of the guidelines for annual review of prescribed adaptive/assistive equipment for fit, availability, function, condition, and effectiveness; ▪ Implementation of a systematic monitoring schedule to report on the availability, condition, and use of adaptive/assistive equipment. ▪ In addition, incorporation of an interdisciplinary assessment of the function, condition, and effectiveness of individuals' bedrails. The assessment should assess the relative risk of using the bed rail compared with not using the bed rail, and thoroughly consider if other options would provide the same benefit while reducing the risk. The use of bed rails should be based on an individual's needs, and should be documented clearly and approved by the IDT team. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> Based on interview with the HT Director and documentation submitted, in December 2011, therapists had initiated a new Compliance Monitoring tool. The tool was designed to monitor staff compliance with positioning, meals, snacks, medication administration, oral care, bathing, lifting/transfer, and communication. Copies of the monitoring forms were being provided to the Residential Coordinator and Unit Manager. A meeting was to be scheduled to discuss the development and implementation of monitoring form action plans and a tracking system to ensure closure for identified issues. The Compliance Monitoring tool data was being entered into a database, but at the time of the review, no analysis of the monitoring data had been initiated. No Facility policy	

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		and/or procedures defined the monitoring process for staff compliance with PNMPs, dining plans, and OT/PT programs. The Compliance Monitoring tool is discussed in further detail with regard to Section O.6. The Provision Action Information for Section P.4 reported that nursing staff had monitored 24 of 35 individuals (69%) who received enteral nourishment. However, it was unclear why the sample did not reflect the entire population of 43 individuals who received enteral nourishment. It was noted that data was limited, but no notable trends had been identified. In addition, it was noted that on a positive note, direct support professionals and nurses appeared to understand the risk associated with improper positioning during enteral feeding. However, no analysis of the monitoring data was provided to substantiate the Facility's findings. In addition, no data was presented to verify that nursing staff had completed competency-based performance check-offs to test their competency to monitor staff's compliance with PNMPs when an individual received enteral nourishment. A review of monitoring documentation for the individuals in Sample P.3 found: ▪ One of the 19 individuals (5%) (Individual #78) received individual-specific monitoring for staff compliance with their PNMPs and dining plans. An HT PNMP Observation, dated 11/28/11, had been completed for Individual #78. Individual #78 was at high risk for aspiration, choking, falls, fluid imbalance, fracture, osteoporosis, respiratory, urinary tract infections, and weight. Individual #78 should have received enhanced monitoring to ensure staff compliance with her PNMP and dining plan strategies. Seven of these individuals had experienced a change in status (i.e., Individual #156 – choking, Individual #164 and Individual #213 – fracture, Individual 280 – recurrent vomiting, Individual #26 – unplanned weight loss, Individual #322 – falls, and Individual #78 – skin breakdown). These individuals should have received individual-specific monitoring after their change in status to verify that PNMP and dining plan strategies were effective and to verify staff compliance with their plans. ▪ Seventeen of 19 individuals had a PNMP. Individual #26 and Individual #198 did not have a PNMP. Nineteen of 19 individuals had a Dining Plan. The only individual within this sample with individual-specific monitoring was Individual #78. Individuals with PNMPs and dining plans should be monitored, to ensure staff's competency and compliance with individuals' PNMPs and dining plans. The Facility should define the monitoring frequency for individuals with PNMPs and dining plans. ▪ Fourteen of 19 individuals' Integrated Risk Rating forms identified PNM high-risk rankings. Individuals with PNM high-risk ratings were not provided with enhanced monitoring.	

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		Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.5 of the Settlement Agreement). As noted above, one of 19 individuals in Sample P.3 received individual-specific monitoring. However, a review of the one HT PNMP Observation form for Individual #78 reported the PNMP was not in use by staff. However, the form did not address any action taken for staff not having Individual #78's PNMP available. There were no follow-up monitoring completed to check staff's compliance with the availability and use of Individual #78's PNMP during her daily activities. On a positive note, the Facility's Self-Assessment noted that a monitoring database was being developed that would provide data regarding concerns noted during monitoring. The data was to be evaluated by the ADOP and/or a designee to confirm individual-specific and systemic concerns had been brought to closure. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. As discussed above, adequate monitoring safeguards were not in place to ensure individuals had adequate and appropriate adaptive/assistive equipment. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This 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 Job Requisition Coordinator and Director of HT should continue to recruit for the three OT vacancies and one PT vacancy. (Section P.1)
2. The HT Department should integrate the State-established OT/PT assessment guideline content into the two Facility OT/PT assessment formats. (Section P.1)
3. The HT Department should initiate audits of individuals' OT/PT comprehensive assessments and assessment of current status to verify compliance with necessary elements, including but not limited to the required State-established guideline elements, timely completion, recommendation for SAPs as appropriate, HOBE assessment data for individuals who were prioritized to receive this assessment, and a comparative analysis of an individual's functional status from year to year. (Section P.1)
4. The HT Department should produce data in the future to document compliance with staff completion of competency-based training and performance check-offs for core PNM competencies and individual-specific strategies for PNMPs, dining plans, and OT/PT programs. The data should identify the number of staff to be trained (N) and the number of staff who have successfully completed a performance check-off. This compliance data should be provided for staff completion of core PNM competencies, PNMP individual-specific strategies, and OT/PT programs beyond a PNMP. (Section P.3)
5. The HT Department should expand the NEO assessment checklist for positioning to require staff to demonstrate one or more alternate

positions. In addition, the Mealtime assessment checklist should be modified to require staff demonstration of individual-specific presentation techniques during a meal. (Section P.3)

6. A policy or protocols should be developed to define to define the system for review of PNMP and dining plan prescribed adaptive/assistive equipment and should include the following:
    a. Definition in the OT/PT assessment formats of the guidelines for annual review of prescribed adaptive/assistive equipment for fit, availability, function, condition, and effectiveness;
    b. Implementation of a systematic monitoring schedule to report on the availability, condition, and use of adaptive/assistive equipment.
    c. In addition, incorporation of an interdisciplinary assessment of the function, condition, and effectiveness of individuals' bedrails. The assessment should assess the relative risk of using the bed rail compared with not using the bed rail, and thoroughly consider if other options would provide the same benefit while reducing the risk. The use of bed rails should be based on an individual's needs, and should be documented clearly and approved by the IDT team. (Section P.4)
7. The HT Department personnel should develop procedures for the PNMP Clinic to document an individual's medium and high-risk indicators that might impact therapeutic interventions; present a comprehensive list of an individual's PNMP adaptive, mealtime, and communication/hearing equipment; document the appropriate therapist's assessment of prescribed equipment for fit, availability, function, condition, and effectiveness; document attendance by therapist signature and date; and document the date of recommendation for new and/or modified equipment, date of work order, delivery of equipment, and frequency of equipment monitoring. (Section P.4)
8. The Facility should develop and implement the audit tools, databases and systems presented in multiple action steps in Section P.1 through P.4. The data produced from these tools and/or systems should be used to verify compliance and/or noncompliance. (Facility Self-Assessment)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: o **Review of Following Documents**: o Ant State and/or Facility policies, procedures, and/or other documents addressing the provision of dental care. If changes since the Monitoring Team's last visit; o For the past six months, minutes from the Dental Peer Review Committee; o Lists of individuals who within the past six months: a) For newly admitted individuals, were seen for dental services, provide date of admission, and date of initial evaluation; b) Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; c) Have refused dental services; d) Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; e) Have had a tooth/teeth extraction; f) Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.); g) Have had preventative dental care; h) Have had restorative dental care; and/or i) Were due for annual dental exams whether they have had exams, and whether the dentist was able to complete those exams; o Most recent comprehensive exams for one individual from each residence – copy from dental office's record of visit and copy from active record of same visit, with identification of source of documentation for each record provided for: Individual #38, Individual #312, Individual #77, Individual #107, Individual #59, Individual #34, Individual #111, Individual #31, Individual #79, Individual #190, Individual #265, Individual #60, Individual #120, Individual #271, and Individual #215; o Five most recent oral surgeries consults and progress notes past six months; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancements reports, including subsequent corrective action plans; 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, including reason for appointment - prophylaxis, annual, etc.; o List of other reasons for missed appointments per date for past six months, including reason for appointment - prophylaxis, annual, etc.); o List of those who have not seen dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards and type of x-ray that is needed to fulfill requirement/ recommendation;

	o List of those who were edentulous at time of the last on site visit, and those who have become edentulous since that time; o List of no shows/missed appointment per building per month for the last six months; o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, residential manager, team, etc.); o QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows, for the last six months; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment for: Individual #7, Individual #131, Individual #112, Individual #174, and Individual #51; o Appointment schedule for those undergoing general anesthesia/conscious sedation; o For six individuals undergoing general anesthesia/conscious sedation, copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc. for: Individual #38, Individual #77, Individual #111, Individual #190, Individual #112, and Individual #271; o For the past six months, copies of any correspondence concerning restraint and sedation use for office visit (to QDDP, team, psychologist, etc.); o Complete dental records for prior three years at SSLC (all documentation including progress notes, prophylactic, annual emergency, restorative, etc. forms, x-ray consult reports, restraint check list, oral surgeon consults, etc.) for one individual most recently seen from each residential unit. Dental records of following individuals were submitted: Individual #77, Individual #184, Individual #59, Individual #10, Individual #116, Individual #109, Individual #321, Individual #140, Individual #190, Individual #104, Individual #165, Individual #271, Individual #266, Individual #310, and Individual #78; o For eight individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring (include pre-treatment sedation sheets), including for: Individual #276, Individual #203, Individual #181, Individual #260, Individual #17, Individual #308, Individual #232, Individual #215; o Current list of HRC approved dental/medical restraint with sedation; o Any restraint and sedation tracking list/system used by the Dental Department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach, such as lower dosage, less mechanical restraint duration, etc.); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits;

	o For most recent four extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure for: Individual #20, Individual #34, Individual #28, and Individual #51; o For those completing annual exams in past six months: ▪ Oral hygiene rating in each exam listed per individual and date of exam; ▪ Quarterly oral hygiene ratings, if done; and ▪ Corrective action plans related to Oral Hygiene ratings; o List of those who receive suction tooth brushing treatment; o Last 10 annual dental summaries completed in last 30 days and for the prior year of these same individuals: Individual #77, Individual #299, Individual #41, Individual #35, Individual #100, Individual #314, Individual #296, Individual #13, Individual #28, and Individual #215; o List of annual assessments (with dates) completed in last six months, and the date of previous annual assessment, including copies of annual assessments; o Most recent annual dental summary provided for the ISP for: Individual #82, Individual #147, Individual #161, Individual #50, Individual #190, Individual #324, Individual #230, Individual #121, Individual #115, and Individual #84; o Most recent/current Facility oral hygiene data (percentage good, fair, poor ratings); o For dental exams, definitions of "C" and "A;" o For individuals with completed dental exams 10/2/11 to 10/9/11, and 2/11/12 to 2/29/12, the oral hygiene rating/score; o Any offsite oral surgery consults for last six months; o For those that are edentulous, list of those with dentures; o For those that are edentulous without dentures, list reason with documentation from the record; o Dental refusal ISPAs; o Summary information on desensitization plans - updated; and o Presentation Book Section Q. o **Interviews with**: o Russell Reddell, DDS, Dental Director; o James Lemon, DDS, Staff Dentist; and o Allison Reed, Dental Hygienist.
	Facility Self -Assessment: Since the Monitoring Team's previous review, the Facility had made changes to the way it presented its self-assessment information. Using a new format from State Office, the Facility had identified activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. Additionally, an updated "Provision Action Information" was submitted. For Section Q.1, the Dental Department no longer was able to derive data from the old databases, because a

	new database was in the process of being implemented. However, the database entry process was slow. This required the Dental Department to rely on calculations by hand. The Dental Department was able to provide data tracking for completion of annual exams (125% - this did not make sense, given that compliance cannot be more than 100%), new admission exams (100%), oral hygiene ratings, timeliness of treatment for emergencies, and justification of extractions. For Section Q.2, the Dental Department had calculated a no show rate of 15%, and a refusal rate of 1.8%. The Facility's Self-Assessment also indicated that 19% of desensitization plans were implemented. However, the Monitoring Team's review indicated that compliance with annual dental exams was 66%. Individuals that had been newly admitted were seen in a timely manner. The Dental Department was only in the initial stages of resolving the reason for the number of missed appointments, and a work group recently had been developed to determine the reasons for the missed appointments. According to the Dental Department, no ISPAs had been held to address refusals. No data was available from the Dental Department concerning progress in the implementation of the dental desensitization programs in place. The recent computerized data also appeared to need further review and interpretation. In addition, the Facility's self-assessment mainly focused on the presence or timeliness of documents or supports, and did not address important quality or content considerations. As the Monitoring Team's reviews do, the Facility's assessment should incorporate key indicators to address both content and quality. Based on a review of the Facility's Self-Assessment of Section Q, the Facility found it was out of compliance with both of the subsections. This was consistent with the Monitoring Team's findings. However, a concern with the Facility's Self-Assessment for Section Q.1 was the basis for the overall finding. Although the Monitoring Team agrees with the Facility's assessment that it remained out of compliance with this provision, the data presented, and the analysis of that data were insufficient to substantiate the Facility's finding.
	Summary of Monitor's Assessment: Since the last Monitoring Team's visit, the Dental Department did not make measurable progress. In part, this was due to problems related to lack of access to the old database, and the problems related to the new database, which did not yet include complete information. Consequently, there was little to no computer-generated information. Everything had to be hand calculated, and files had to be manually searched. This created delays in progress in every aspect of dental care. A number of important documents appeared to be missing from some of the dental records the Monitoring Team reviewed. This included such documents as the annual examination, periodontal chart, dental sedation plan, current treatment plan, current consent, and a copy of the HRC-approval document. The rate of timely annual examinations was determined to be 65%. The annual dental summaries provided important information to the IDT members in lay language. However, many were created based on dental examinations several months earlier, raising the concern that

	they potentially were no longer accurate due to the length of time from the examination. The Dental Department did not make progress on reducing the missed appointment rate. The latest oral hygiene scores appeared to be slightly worse than in prior months. The dental hygienist had not been able to provide in-service training in the residences.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The Dental Director, one Dental Hygienist, and two Dental Assistants staffed the Dental Department. Since the Monitoring Team's last visit, a part-time Dentist also had been added to the Department. A list of those certified in CPR was submitted, dated 2/7/12. The list indicated the two Dental Assistants and part-time Dentist were certified. Other personnel in the Department were not listed. However, according to information the State provided in response to the Monitoring Team's draft report, the Dental Director and Dental Hygienist were up-to-date on CPR. <u>Annual Assessments</u> For the six months prior to the Monitoring Team's visit, a list of those individuals having annual examination appointments was submitted. A number of individuals with annual examination dates prior to this six-month window of time were included. The list included individuals with dates of the most recent annual dental assessment and the prior assessment for 93 individuals. Of these, 61 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 66%. For 30 of the 93 individuals (32%), the annual dental examinations were within a few months of the previous exam. It is recommended that the Dental Department review this data to determine the reason for the overdue status for 34% of the individuals, as well as what appeared to be excessive or frequent annual assessments for 32% of the population. Copies of the completed annual assessments for 15 individuals were submitted. Each included the annual assessment from the IPN entry, and the dental progress note (DPN) entry. The following findings were made with regard to the IPN and DPN notes related to the annual assessments: ▪ All of the 15 submitted assessments had an entry in both the IPN and DPN (100%). ▪ Thirteen of the 15 individual annual assessments had identical information in the IPN and DPN, resulting in a compliance rate of 87%. ▪ Oral cancer screening was documented in 12 out of 15 IPNs (80%).	Noncompliance

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		▪ The plan for the next visit was documented in both the IPN and DPN in 13 of the cases (87%). Additionally, during this time period (from 9/6/11 to the time of the Monitoring Team's onsite review), three individuals were admitted to LBSSLC. Three out of three (100%) had completed an initial dental exam in the first month (from 13 to 26 days after admission). The Dental Department documented that all individuals residing at LBSSLC had seen the dentist in the prior year. Copies of the complete dental record for the prior three years were submitted for one individual from each residence. This provided a total of 15 dental records for review. ▪ A current annual examination was recorded in 13 of 15 dental records (87%). ▪ A dental progress note was submitted in 15 of 15 cases (100%). ▪ A dental IPN was submitted in six of 15 cases (40%). ▪ Dental sedation plans were submitted for none of 15 cases (0%). ▪ A periodontal chart was submitted for none of 15 cases (0%). ▪ A current annual dental summary was submitted for 12 of 15 cases (80%). ▪ A current dental record annual examination (Form LuSSLCD-1) was submitted in seven of 15 cases (47%). ▪ A current treatment plan record was submitted for three of 15 cases (20%). ▪ Current consents were submitted for 10 of 15 cases. ▪ For those with current consents, six of 10 had current HRC-approval documents (60%). It is recommended that the Dental Department review the content of the dental records and develop a comprehensive packet that provides all documentation of dental care in typed format. If gaps are found, such as lack of a periodontal chart, dental sedation plans, dental record annual examinations, or current consents and HRC-approval, then a tracking and monitoring system is needed to ensure the dental records are complete and up-to-date at all times. Assuming the submitted information was the comprehensive packet requested, a number of significant gaps were found in the documentation in the Dental Department copy of the dental record or in the dental section of the active record located in the residence. For instance, the current dental record annual examination (Form LuSSLCD-1) was a two-page document that was preprinted and needed minimal responses. It was considerably more comprehensive than the annual exam in the IPN or DPN notes that were entered using a small stamp. The second page of this form included an odontogram (tooth chart) and the current treatment plan record. This form was completed internally and used in the creation of the annual dental summary, which was distributed to the IDT members. However, a current copy of this essential document was	

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		only submitted in 46% of the cases. Oral Hygiene An oral hygiene index was completed on each individual at the time of the annual exam. The most recent oral hygiene scores were submitted for exams completed from 10/1/11 through 2/29/12. According to this document, 111 individuals were examined and an oral hygiene score rating was recorded for each. Of these 111 individuals, 21 individuals (19%) had a good oral hygiene score, 70 (63%) had a fair oral hygiene score, and 20 (18%) had a poor oral hygiene score. From a separate database for the time period from 1/1/12 through 2/24/12, there was preliminary information concerning oral hygiene. According to this information, 11 individuals had oral hygiene rated, including five as fair, four as fair to good, and two as good. From a separate list, undated but scanned on 2/23/12, Facility-wide oral hygiene data was submitted. No information was included regarding the length of time over which the oral hygiene data was collected, but it was interpreted to mean the last available oral hygiene score for each individual. The data indicated that 33.93% had an oral hygiene rating of good, 51.58% had an oral hygiene rating of fair, and 14.47% had a score of poor. This might indicate the trend of worsening oral hygiene when compared with the more recent data already mentioned (from 10/1/11 through 2/29/12, which represents the most recent oral hygiene scores available for those with recent assessments). For example, if 33.93% of the individuals had a good rating based on the campus-wide data over a year or more, but the more recent months indicated only 19% had a good oral hygiene rating, this showed a potentially problematic trend. In this case, the Dental Department needed to review the accuracy of the data, and based on that analysis, determine the need to develop appropriate action plans. However, providing data without appropriate timeframes and numbers of individuals included in the data made it difficult, if not impossible, to analyze trends. To ensure accurate interpretation of results, the Dental Department should ensure all data generated from the department has precise dates to which the data applies and the number of individuals involved, along with other relevant details. 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 221 (25%) of the population. Eight of the 15 residences had individuals that required suction tooth brushing. The Action Plans for the Dental Department included two entries for the Dental Hygienist to provide observation and coaching to each of the residences once monthly in order to	

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		reinforce and improve oral hygiene and positioning. When asked for the schedule of visits, the response was the schedule could not be maintained, and no current monthly visits were made to the residences, because of too many demands on the time of the one Dental Hygienist in the Dental Department. The Dental Department submitted information concerning two initiatives to improve oral hygiene at LBSSLC. ▪ There were plans for training of staff in oral hygiene. The Infection Control Committee minutes reflected the progress in completing the steps necessary for this process. According to the October 6, 2011 minutes, the Dental Hygienist was prepared to in-service all residential staff that would assist with oral care of the individuals. The Nurse Educator would in-service the nursing staff. The minutes of 12/15/11 indicated that new cabinets for personal protective equipment were to be available in residences in which individuals required assistance with oral hygiene. According to the 12/15/11 minutes, the cabinets with universal locks were available. In addition, at that committee meeting, it was determined they would be placed in changing areas or grooming areas in the residences. The 1/10/12 Infection Control Committee minutes indicated that work orders for installation of the cabinets would occur that week. As of the Monitoring Team's visit, the dental hygienist's in-service training of the residential staff had not occurred. However, the Dental Department's plan was for the dental hygienist to provide an in-service focusing on proper brushing technique and dental plaque identification. The in-service also would address behaviors and head movements during tooth brushing. Staff were also to be trained on the use of a "two tone disclosing solution." This tasteless solution colored new plaque red and old plaque blue. Designated staff in the residence or the Dental Department staff would apply this solution. According to the Dental Department, it would allow determination of whether the teeth were brushed twice daily, and if tooth brushing was being done effectively. The purpose would be to provide direct support professionals with visual information about which teeth were missed while brushing or needed further brushing. It also would be a visual aid to individuals to assist them in completing successful tooth brushing. ▪ The second initiative involved suction tooth brushing. An in-service training was completed at LBSSLC, with training by personnel from Lufkin SSLC. Plans were for individuals at LBSSLC needing suction tooth brushing to have their own designated equipment/suction machine. It was expected that this would improve oral care, because the needed equipment was not always available when tooth brushing should have been done. <u>Preventive, Restorative, Emergency Dental Services</u>	

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		According to the Dental Department, 31 individuals were identified as overdue for recommended dental x-rays (full mouth). The list included two individuals that were deceased, indicating a need for improved communication of information between departments. The preface to the list indicated that the Dental Department had not been able to obtain any type of x-ray. The individuals were on a list to receive IV sedation and dental treatment in a hospital setting, presumably including a full mouth x-ray series. This represented 14% of the campus. It is recommended that the Dental Department develop a plan and coordinate with the part-time dentist at LBSSLC to begin to reduce the percentage of individuals without x-rays. Information submitted indicated 18 individuals residing at LBSSLC were edentulous, for a rate of 18 out of 221 (8%). Since the Monitoring Team's last visit, one individual became edentulous. Three of the 18 (17%) had dentures. The Dental Department indicated that "there were no ISP/ISPAs available which address individuals who are edentulous and do not have dentures." It is recommended that the documentation of the active record/IDT minutes/ISP include the justification for the other 15 individuals not having dentures (e.g., offered but refused, dysphagia, behaviors, etc.), or discussion about next steps to move forward in obtaining dentures, implants, etc. A member of the Dental Department should be part of the integrated discussions that occur. Additionally, the Dental Department should have in its records a copy of the section of the ISP or the IDT minutes confirming adequate discussion of this topic. The Dental Department provided the breadth of services required to care for the individuals at LBSSLC. In the prior six months (September 2011 through February 2012), 36 individuals were seen for prophylactic care, with completed or attempted appointments by month as follows: September 2011 - seven, October 2011 – 17, and November 2011 – 14. Additionally, five individuals underwent general anesthesia, which might have included cleaning, but the list did not clarify the purpose of the appointments for general anesthesia. From 9/1/11 through 2/6/12, nine individuals underwent restorative care. Seven individuals completed one restorative visit, one individual completed two restorative visits, and one individual completed three restorative visits. At one visit, between one and 12 fillings were placed. There were a total of 12 restorative appointments. At nine of these appointments, one filling was placed. From September 2011 through February 2012, 10 individuals were seen and treated for dental emergencies. Separately, a document entitled: "Monthly Dental Emergency log 2011" was submitted. For the months of September 2011 through February 2012, 11	

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		individuals were listed. It included a time and date (which was interpreted as the time and date the emergency was called into the department), the chief complaint, the time and date the individual was seen, brief notes of action taken, and resolution date. Ten were considered resolved, one was scheduled for 4/11/12, and one had two follow-up "no shows." It is recommended that the first column be better identified as to the meaning of the date and time to reduce assumptions and confusion. Five individuals underwent dental extractions. Separately, for extractions from 10/7/11 through 1/25/12, information for four of these individuals was submitted. From one to 29 teeth were extracted. Reasons included periodontal disease, bone loss with mobility and infection, recurrent decay, loss of crown of tooth, extensive decay beyond restoration, fractured tooth, and bruxism into pulp. There was no information submitted to indicate a second opinion was obtained for any of the four individuals undergoing extractions. The reasons the dentist provided appeared acceptable in determining the need for the extractions in each case. However, especially when more than one tooth is being extracted, it is valuable documentation to have a second opinion. With the recent addition of a part–time dentist, this should be readily available going forward. Monitoring and evaluation of use of oral sedation was reviewed. Eight active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ Four out of the eight (50%) recorded nothing by mouth (NPO) status. The Dental Department's procedures did not appear include the step of confirming NPO status once the individual arrived for the appointment. It is recommended that once the Dental Department confirm an individual's NPO status (or other instructions, if PO allowed), that the Dental Department documents the status in the dental progress note section. ▪ Eight of eight (100%) dental progress notes listed the medication administered and the dose. None (0%) listed the route in the dental progress notes. ▪ Five of eight (63%) listed pre-procedure vital signs. That the pre-sedation assessment forms were not forwarded for three of the eight was concerning. It could indicate nursing pre-sedation assessments were not completed according to policy and procedure. It is recommended that these forms be copied and kept in the dental record as proof of appropriate monitoring. ▪ Seven of eight (88%) had intra-procedure and post procedure vital signs. The monitor strip was taped to the dental progress note section of the active record. It was noted that the time recorded appeared to be one hour later than the documented procedure for more than one individual. If this was a problem with an incorrect time being programmed into the tape machine, it should be corrected. If not, then other action would be needed to correct the underlying issue.	

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		▪ Adequate documentation regarding effectiveness was found in eight of the eight dental progress notes (100%) of the active records. ▪ The oral hygiene rating was documented in eight of eight dental progress notes (100%). ▪ Tooth brushing instruction was provided to the individual or accompanying direct support staff in one of eight dental progress notes (13%). ▪ Consent for the oral sedation was submitted for seven of eight individuals (87%). ▪ HRC approval was submitted for seven of eight active records (88%). ▪ A sedation care plan was submitted in zero of eight active records (0%). ▪ A completed restraint checklist form was submitted in zero of eight active records (0%). ▪ A post-procedure follow-up dental IPN or DPN was completed in zero of eight (0%) active records. Relevant portions of the active record were submitted for six individuals who had undergone general anesthesia in the prior six months. The date range of these procedures was from 1/6/12 through 2/10/12. The procedures under general anesthesia included one or more aspects of dental care. The list varied in each case, and included one or more of the following: annual examination, prophylactic treatment, extractions, and restorative treatment. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was up-to-date in six of six (100%). ▪ HRC approval covered the time period of the date general anesthesia was given in five of six (83%). ▪ Pre-operative vital signs were recorded in six of six (100%). ▪ Oral hygiene index/rating was recorded in six of six (100%). ▪ A pre-anesthesia record was submitted for zero of six (0%). ▪ The operative anesthesia record was completed in six of six (100%). ▪ A REACT score was submitted in six of six (100%). ▪ A recovery note was submitted one of six (17%). The recovery note was dated for one of one (100%). Separately, a list of those completing an appointment under general anesthesia was submitted for the period from 10/7/11 through 2/10/12. This totaled 38 individuals. Additionally, there were nine individuals rescheduled for the following reasons: insufficient time, not NPO, behaviors, and hospitalized. For four individuals that underwent extractions, the dental record was submitted. The following findings were made, based on the information submitted: ▪ For three of the four cases, IV sedation was used. One had only a local	

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		anesthetic. Two others were also administered a local anesthetic. ▪ For the three cases for which IV sedation was utilized, no anesthesia record or REACT score was submitted (0%). ▪ Pre-procedure vital signs were recorded in the dental progress note in zero of four cases (0%). ▪ From one to 30 teeth were extracted. ▪ Consent was submitted for none of the cases (0%). ▪ Post-procedure vital signs were recorded in the dental progress note in zero of four cases (0%). ▪ Pain medication was provided in two of four cases. ▪ A post-procedure follow up dental progress note was completed for two of four cases (50%). Emergency treatment was reviewed for five individuals. The reasons for the emergency included the following: toothache, pulling at the mouth, and jaw swelling. The following findings are made based on this review: ▪ Three records (60%) documented the presence of pain or not. ▪ The date and time of onset of the emergency was documented in none of the dental notes reviewed (0%). ▪ Vital signs were recorded in one out of five notes (20%). ▪ Tooth brushing instruction to the individual or staff was documented in zero out of five notes (0%). ▪ Oral hygiene rating/index was documented in two of the records (40%). ▪ Treatment was recorded in one record (20%). ▪ One record indicated a restorative procedure occurred at the time of the emergency visit. ▪ Follow-up occurred for one individual (20%).	
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	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 IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. The Dental Department indicated there were no new or modified policies, procedures, or other documents addressing the provision of dental care. <u>Provision of Dental Records to IDTs</u> Copies of annual dental summaries for 10 individuals completed in the 30 days prior to the Monitoring Team's visit and the prior assessment were submitted. These	Noncompliance

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	dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	summarized the dental information in lay terms to assist the IDT in understanding the dental status of the individual. For three out of 10 (30%), the annual dental summary was within 365 days of the prior evaluation. It was noted that the annual dental summary was at times completed several weeks to months after the annual dental assessment/evaluation. As a result, the IDT would be reviewing dental information that was outdated, and might no longer apply. LBSSLC should develop a procedure for the completion of annual dental summaries that ensures the information provided to IDTs is current and relevant to the teams' discussion. Annual dental summaries for which considerable time lapsed from the annual dental assessment/examination to completion of the annual dental summary included the following: for Individual #296 - annual dental summary 1/31/12, and annual dental exam 10/13/11; for Individual #215 - annual dental summary 2/1/12, and annual dental exam 6/29/11; for Individual #299 - annual dental summary 2/1/12, and annual dental exam 9/8/11; for Individual #100 - annual dental summary 2/1/12, and annual dental exam 6/10/11; and for Individual #314 - annual dental summary 2/1/12, and annual dental exam 11/29/11. For 10 of the annual dental summaries, five utilized current information within 60 days of the dental summary being completed (50%). Additionally, the annual dental summary included the date of the last prophylactic treatment/visit. Some of these summaries indicated potentially overdue prophylactic visits based on a prophylaxis/cleaning every six months, including: Individual #13 - annual dental summary 2/1/12, and last prophylaxis 9/20/10; Individual #100 - annual dental summary 2/1/12, and last prophylaxis 6/10/11; Individual #314 - annual dental summary 2/1/12, and last prophylaxis 3/8/10; Individual #41 - annual dental summary 2/6/12, and last prophylaxis 6/21/10; and Individual #35 - annual dental summary 2/1/12, and last prophylaxis 5/14/10. Two of these included comments about the need for treatment at the area hospital due to medical conditions. For one, the comment included that he had two "no show" appointments, and then was scheduled a year later, at which time he was seen. The comments section did not guide the IDT to review the need for timely prophylactic treatments and methods to ensure the individual's compliance, whether at LBSSLC or at the regional hospital, if needed, nor was the team provided information about the appropriate frequency of exams and treatment. In the more recent annual dental summaries, there was also a section entitled: "Community Placement Evaluation," which provided a risk rating of periodontal disease and risk of caries. This was not sufficient information for the IDT as it worked to identify appropriate supports for an individual in a community setting, or for a potential community provider to determine what support configuration the individual would need in a different setting. For example, there was no information concerning what additional	

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		steps would need to be taken to improve an individual's cooperation/compliance, such as having familiar staff accompany the individual, having the residence discuss the upcoming appointment each day for several days, providing the individual a favorite flavored toothpaste, etc. Such individualized techniques would be important for a community provider to know. Additionally, although the use of sedation and type was listed, it was separate from the community section and might need to be repeated, with a brief entry as to effectiveness of prior doses given, and history of any concerns with oral/IV sedation or general anesthesia. In addition, although the prior year summaries included important guidance about the specific tooth brushing needs of the individual, they were generally absent in the most recent summaries. Information about methods of improving oral hygiene should be specific to the individual and assist the team to understand the oral hygiene needs and required steps to accomplish this. The level of staff assistance, areas of the gum needing special attention based on examination, etc. would be important additions to the comment section. Separately, copies of the ten most recent annual dental summaries were provided. These were for different individuals than the ten described in the prior paragraphs. A similar trend was noted in that several had the annual dental summary completed more than 60 days after the last annual exam (i.e., Individual #161, Individual #50, Individual #324, Individual #230, and Individual #84). Five (50%) used timely data in completing the annual dental summaries. There was one annual dental summary, dated 2/1/12, for which the last annual exam was recorded as 2/10/12, indicating the need for review of the information for accuracy. Additionally, it is recommended the second page of the annual dental summary include the name and date of the document. Currently, this information was not recorded on the second page. <u>Refusals/Missed Appointments</u> The Dental Department recently had begun to enter data into a new database, and information gathering was expected to improve with time. The Facility submitted information concerning those individuals that refused dental services. The following lists the month with the number of refused appointments during that month: September 2011 - two, October 2011 – seven, November 2011 – five, December 2011 – three, January 2012 – none, February 2012 - none. There were two individuals that refused two appointments and two individuals that refused three appointments. A separate list entitled: "list of refusals for last six months per date of refusal" indicated that there were two refusals for September 2011, five for October 2011, three for November 2011, and one for December 2011. The Monitoring Team could not determine	

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		the reason for the discrepancy in the listed information. The Facility submitted information concerning those individuals that missed dental services other than refusals. The following lists the month with the number of missed appointments during that month: September 2011 – none, October 2011 - four, November 2011 – eight, and December 2011 – four. Reasons provided included: staffing – two, off campus – one, hospitalized – one, not aware of appointment/no schedule sent – four, not NPO –four, time constraint – one, and no show – one. Subsequently, the individual completed the dental appointment in 12 out of 16 (75%). There was an appointment later in 2012 for two of these individuals. For two individuals, the appointment was not scheduled due to health concerns of the individual. The time between the missed appointment and the completed appointment varied from two weeks to two and a half months. Separately, a list of "no shows" was submitted for these same months. There appeared to be overlap with the other two refusal and missed appointment lists, but it was difficult to interpret the information. It listed seven individuals for September 2011, six for October 2011, 12 for November 2011, three for December 2011, and five for January 2012. It documented when appointments were rescheduled, but not all appointments were confirmed as having been completed. From these 33 "no show" appointments, there was documentation of a completed appointment in this document or in other submitted documents for 15 out of 33 individuals (45%). A list of "no shows" was tabulated based on residence. For those residences with increased numbers of "no show" appointments, the Dental Department should further investigate the cause, and assist and guide the IDTs in developing and implementing a plan to ensure dental appointments are completed. Targeting residences with increased "no show" rates would focus attention in areas with the most urgent need, and allow increased collaboration with the staff and/or other disciplines, such as psychologists, etc., depending on the reasons for the no shows. Based on information in the new database, a graph was submitted entitled: "cancelled and no show appointments by reason" for the reporting dates 1/1/12 through 2/24/12. This documented that there were seven "no shows" during this time for unknown reasons, there was one cancellation for not being NPO status, and there was once cancellation initiated by the dental clinic. Additionally, there was a graph entitled: "cancelled and no show appointments by home" with the reporting dates of 1/1/12 through 2/24/12. However, the numbers appeared to be much greater than the numbers included on the lists discussed in the prior paragraphs. For instance, for each of five residences, there were 14 or more cancellations or no show appointments, which	

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		totaled in excess of 70 cancellations or missed appointments. The time period also appeared to need to be reviewed, because the excessive number of cancellations or "no show" appointments for this seven-week period appeared to be inconsistent with other submitted lists. An additional graph entitled: "Dental appointments by reason" documented that the annual exam was responsible for most of the dental clinic appointments, followed by recalls and prophylaxis, and TIVA. There was one bar of the graph that was unlabeled. Further, for all these visits to occur in a 7-week time period seemed problematic. A prior document indicated that 95 annual exams had been completed in six months, and the large differences in database information needed further review, as a prior graph indicated there had been only 13 appointments in that 6-week range. A graph was submitted entitled "Dental appointment attendance - all appointments (including refusals)." It appeared the "I," II," and "III" referred to the residential units. There was an additional column with no title and, therefore, it could not be interpreted. It appeared that the number of dental appointments completed was far less than the number not attended. For Unit I, 40 appointments were recorded, but only three attended. For Unit II, 23 appointments were recorded, but only one attended. For Unit III, there were 42 appointments, but only six attended. This graph was confusing, because the next graph indicated that 92% of the appointments were attended in January 2012, and 100% in February 2012. However, in January 2012, about 125 appointments were scheduled, and in February 2012, 140 appointments, which did not appear accurate based on other information submitted. One graph had unintelligible script. It would appear that the Dental Department and/or QA Department had not reviewed this information, because there was great need for clarity. A separate set of graphs and tables was submitted with the reporting dates of 8/1/11 through 2/24/12. A chart entitled: "Missed appointments by home and month documented an increase of missed appointments from August 2011 to January 2012. There were 19 missed appointments in January 2012 (versus 13 appointments kept in January 2012 from the computer generated information), compared to only two in August 2011. Fourteen of the 19 were for unknown reasons, indicating the need for rigorous and timely follow-up of "no shows" to determine the cause. For the entire time period of August 2011 through January 2012, there were 40 "no show" appointments. The cause for 23 of these was unknown (58%), which indicated a need for considerable effort to determine the cause of the "no shows." Another table entitled: "Counts/percentages of anesthesia, pre-sedation, and mechanical restraints" indicated no mechanical restraints, and no pre-sedation were used, and	

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		anesthesia was used for only one appointment. It was unclear over the five month span from August through January (December was excluded, but not explained), the meaning of the "total appointment" column, because it only tallied 26 appointments. A computerized chart entitled: "dental appointments attendance sheet" for 8/1/11 through 2/24/12 was submitted. It listed 59 appointments, with 44 attended (44%). A review of the list indicated 13 cancellations, 17 "no shows," and three refusals. The appointments that were scheduled were for a wide range of procedures, including recall/prophylaxis – nine, annuals – four, Total Intravenous Anesthesia (TIVA) – one, restorations – one, and initial exam – one. Although the list of appointments appeared small for the six-month time period, it indicated that there were large numbers of appointments missed. This indicated a need for Dental Department review and collaboration with the IDTs in improving the show rate for dental appointments. The Dental Department indicated it was in the process of creating a "no show" work group to focus on the breakdown in communication between the residences and the dental clinic. No information was provided regarding whether a work group had convened. The Facility submitted no minutes reflecting the progress of this work group. That such a workgroup was just now being created over two years into the Settlement Agreement was problematic. For comparison, the Dental Department hand counted the number of appointments for the prior six months, and calculated a total of 426 appointments. The Dental Department indicated: "Our appointment book has been our only means of tracking dental/hygiene appointments for the past six months. Our old database was made obsolete due to the new database being installed. Up until February, when all facilities were adding to and making changes to the database, it had not been ready for data entry. Our intention is to resume data entry beginning April 2012." In order for the contents to be understood and properly interpreted, the charts and graphs becoming available through the new database needed considerable review and improved labeling. The numbers listed appeared inconsistent with the other lists the department submitted. Overall, the data submitted needed further review before it could be utilized. BSPs were submitted for some individuals with known refusals or "no shows" at the dental clinic. When comparing the list of those that refused, some individuals were since able to complete the dental visits. Individual #75 and Individual #108 completed dental appointments. Individual #38 was no longer on the refusal list, with the implication that he completed a dental visit since his BSP of 2/10/11. However, three individuals on a list of those with missed appointments still needed to complete a dental visit (i.e., Individual	

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		#240, Individual #273, and Individual #60). BSPs or ISPAs for these individuals were not submitted for review to determine if "no show" dental appointments were addressed. An unsigned behavior contract for Individual #240 was submitted, but the context of the contract and the discussion/decision of the IDT were not included. Separately, the Dental Department submitted a document that stated that there were "no ISPAs addressing dental refusals." It is recommended that a member of the Dental Department attend ISPAs to address repeated dental refusals or repeated "no shows," and assist teams in developing and implementing action plans to address underlying issues. It is recommended that the Dental Department maintain copies of ISPAs, ISPs, and/or BSPs that document actions taken to address dental concerns of the individuals, especially refusals and "no shows." This information should be shared with all the Dental Department staff, with internal meetings to develop further corrective actions, if needed. Such recommendations could then be shared with the IDT for discussion. However, to have no ISPAs addressing refusals indicated a lack of integrated care related to this aspect of the individual's health. <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 September 2011 through February 2012, according to the data provided, there were 178 appointments kept (there were 426 appointments scheduled in this same time period). Of these 178, there were eight appointments in which oral sedation was given (4%). Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation, dated 2/21/12. A total of 117 individuals were listed that required dental sedation. Of these, 88 had consent for dental restraints (types not identified in this document). Of the 117 utilizing dental sedation, 24 utilized IV sedation and 56 used general anesthesia. Of these, 104 had current consents for dental restraints/sedation (89%). The Facility submitted a packet utilized to track restraint use, the "restraint checklist" form. Part of the packet was entitled "Pre-sedation assessment (sic)," and included a section to document the effectiveness of the medication used in pre-treatment sedation. The Psychiatry, Pharmacy, Medical, and Dental Departments were to sign the last page of this form. If utilized, it created a log of sedation use and determination of need for adjustment of dosage or change in medication based on the individual's response to the prior medication and dosage. Each time sedation was given, a document was created that recorded whether the level of sedation that was necessary for the procedure was	

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		obtained, or whether the person was too sedated, or sedation failed. This information could readily be entered into an ongoing log per individual. Then, each time a procedure is indicated, the dentist/PCP could review what was administered and the effectiveness. However, although this form existed, the Dental Department indicated it did not use such a tracking system in the Department. It is recommended that this log be developed, and the information entered for each individual requiring sedation. Benefits of the log would include an improved success rate of procedure completion, because the dentist would have a guide regarding dosage based on prior attempts with the individual. It would potentially reduce both appointment rescheduling for incomplete procedures, as well as under-sedation and over-sedation. It would provide the dentist with important historical information when ordering sedation for a dental visit. Concerning progress in desensitization, ▪ A total of 113 individuals had been identified as requiring a desensitization or other plan to reduce the need for restraint. ▪ Of these, 20 (18%) had plans developed for dental desensitization, dated from 9/1/11 to 2/17/12. There were two additional individuals with both dental and medical desensitization needs. Nine of these individuals (8%) had desensitization plans in skill acquisition program format. ▪ No data was submitted to indicate any of these plans were being implemented consistently, and, when appropriate, changes were being made to them. Many of the plans were developed recently, and would not have been expected to have sufficient data for interpretation. ▪ There were two Desensitization Committee meetings held, for which information was submitted. These were held on 1/13/11 and 3/22/12. There were no minutes submitted of either meeting. Information distributed included a list of individuals on the "Desensitization Priority List," a copy of the "Dental Desensitization Assessment Form," and an informational sheet entitled: "Four Stages of Desensitization."	

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

1. The Dental Department should review the data concerning annual assessments to determine the reason for the overdue status for many individuals, as well as the excessive or frequent annual assessment for many other individuals. (Section Q.1)
2. The Dental Department should review the content of the dental records and develop a comprehensive packet that provides all documentation of dental care in typed format. If gaps are found, such as lack of a periodontal chart, dental sedation plans, dental record annual examinations, or current consents and HRC-approval, then a tracking and monitoring system should be instituted to ensure the dental records are complete and up-to-date at all times. (Section Q.1)
3. To ensure accurate interpretation of results, the Dental Department should ensure all data generated from the department has precise dates to which the data applies and the number of individuals involved, along with other relevant details. (Section Q.1)

4. The Dental Department should review data related to individuals' oral hygiene ratings, and if problematic trends are discovered, action plans should be developed and implemented to address them. (Section Q.1)
5. The Dental Department should develop a plan and coordinate with the part-time dentist at LBSSLC to begin to reduce the percentage of individuals without up-to-date x-rays. (Section Q.1)
6. For individuals who are edentulous and do not have dentures, the documentation of the active record/IDT minutes/ISP should include the justification (e.g., offered but refused, dysphagia, behaviors, etc.), or discussion about next steps to move forward in obtaining dentures, implants, etc. A member of the Dental Department should be part of the integrated discussions that occur. Additionally, the Dental Department should have in its records a copy of the section of the ISP or the IDT minutes confirming adequate discussion of this topic. (Section Q.1)
7. The Dental Department should review and amend the emergency log to reduce confusion and need for assumptions. (Section Q.1)
8. Once the Dental Department confirms an individual's NPO status (or other instructions, if PO allowed), the Dental Department should document the individual's status in the dental progress note section upon his/her arrival at the dental clinic. (Section Q.1)
9. LBSSLC should develop a procedure for the completion of annual dental summaries that ensures the information provided to IDTs is current and relevant to the teams' discussion. (Section Q.2)
10. The comments section of the annual dental summary should include a review of the need for timely prophylactic treatment and methods to ensure the individual's compliance/cooperation, steps taken to improve compliance, sedation needs should the individual transition to the community, and specific tooth brushing and oral hygiene needs of the individual. (Section Q.2)
11. The second page of the annual dental summary should include the name and date of the document. (Section Q.2)
12. For those residences with increased numbers of "no show" appointments, the Dental Department should further investigate the cause, and assist and guide the IDTs in developing and implementing a plan to ensure dental appointments are completed. (Section Q.2)
13. Given the vast discrepancies in the data submitted, the Dental Department should review the database information and resolve the differences. (Section Q.2)
14. The Dental Department, working in conjunction with residential services and the IDTs, should develop a systematic and persistent approach to reduce and eliminate the "no show" appointments due to unknown reasons. (Section Q.2)
15. In order for the contents to be understood and properly interpreted, the charts and graphs becoming available through the new database should be reviewed and the labeling improved. (Section Q.2)
16. A member of the Dental Department should attend ISPAs to address repeated dental refusals or repeated "no shows," and assist teams in developing and implementing plans to address the underlying issues. (Section Q.2)
17. The Dental Department should create a log of sedation use, including level of effectiveness. (Section Q.2)

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 LBSSLC Section R Presentation Monitors' 4th Compliance Visit March 2012; o The following documents: Speech Language Pathology assessment, ISP and ISPAs for past year, Positive Behavior Support Plan, SLP consultations for the last year, competency-based training and performance check-offs for communication, SLP direct therapy plan, SLP progress notes, monitoring for communication equipment, Integrated Risk Rating form, IDT Risk Action Plan, and daily schedule for following 24 individuals: Individual #20, Individual #239, Individual #277, Individual #179, Individual #1, Individual #60, Individual #260, Individual #56, Individual #131, Individual #31, Individual #273, Individual #254, Individual #135, Individual #53, Individual #25, Individual #313, Individual #250, Individual #26, Individual #238, Individual #45, Individual #283, Individual #232, Individual #146, and Individual #140; o Continuing education completed by SLPs since the last on-site review, various dates between 9/11 and 2/12; o List of current SLP and audiology staff with corresponding caseloads, undated; o List of Individuals with Augmentative/Alternative Communication (AAC) devices, undated; o Communication Master Plan List, undated; o AAC Evaluation and Speech Language Assessment (template), undated; o Speech Language evaluations completed for individuals newly admitted to Facility since last on-site review, various dates from 11/11 through 1/12; o Tracking log of completed assessments completed from 7/11 through 2/12; o AAC Equipment Monitoring forms and Compliance Monitoring forms that SLPs, SLPAs, and PNMP Coordinators have used since last on-site review, updated 1/14/12; o Competency-based performance check-off sheets, including AT/AAC Competencies (templates) implemented since last on-site review, dated 2/12; o Summary reports or analyses of monitoring results related to communication generated by the Facility, including action plans and Quality Assurance reports, from 1/11 through 1/12; o AAC-related spreadsheets, from 1/11 through 2/12; o List of individuals receiving direct speech services and focus of intervention, undated; o List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior, dated 2/13/12; and o List of Individuals with PBSP's and replacement behaviors related to communication, dated 2/13/12. ▪ **Interviews with**: o Linda Thomas, Director of Habilitation Therapy; o Debbie Jones-Ellison, MS, CCC/SLP, Dysphagia Specialist;

	○ Stephanie Carrillo, MS, CCC/SLP; and ○ Natalie Quinonez, MS, CCC/SLP. ▪ **Observations of**: ○ Observations in the following day/vocational sites and residences, including dining rooms: 504 East Quail, 504 West Sparrow, 528 North Cedar Avenue Zinnia, 513 South Cedar Aspen, 536 Magnolia Boulevard Workshop, 524 North Cedar Avenue Lilly, 525 North Cedar Avenue Rose, 526 North Cedar Avenue Tulip, 514 South Cedar Avenue Birch, and 539 Lark Street Activity Center.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement, the Facility found it was in noncompliance with any of the subsections of Section R. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: LBSSLC Self-Assessment, Action Plans, and Provision Action Information. The LBSSLC Self-Assessment listed the steps the Facility staff completed or planned to complete to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The LBSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. The Facility Self-Assessment included minimal data or findings from the self-assessment activities to support the Facility's conclusion that it was not in substantial compliance with the requirements of the Settlement Agreement for Section R. A review of the Facility Self-Assessment for Section R identified activities engaged in to conduct the self-assessment. However, some of the action steps had not been completed. Action steps in Sections R.1 through R.4 indicated that audit tools, databases, and/or systems were in the development phase. As the Facility recognized, additional work was needed to create review systems that will allow the Facility to identify where it is doing well, and where additional work is needed. Once these systems are developed and implemented, the Facility should have the data it needs to better support its findings related to compliance. The Facility should develop and implement the audit tools, databases and/or systems identified as being "under development" within these sections. Additional detail on Facility self-assessment activities and results is provided at the beginning of each section. The QA/QI Quarterly Summary for Section R for August, September, and October 2011 reported overall inter-rater reliability scores for August was 100%. However, it was not clear that the Facility had an adequate system for determining inter-rater reliability, and/or the validity of the findings. There were no inter-rater reliability scores for September or October. The summary noted that HT Department monitoring was temporarily deferred in October, November, and December 2011, and January 2012 until additional therapists were hired. No compliance percentages were provided for individual-specific monitoring indicators in Section R. Without this information for August and September, sufficient information and/or data was not available to allow the Facility to analyze its compliance, and identify areas in which progress had been made as well as

	areas in which work was needed. The Facility should develop and implement a consistent format to present data from the monitoring tools in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. In addition, the presentation of data should include the total population being reviewed (N), and the sample of the population (n) to yield a percent sample to indicate the relevance of compliance scores. Specific compliance scores for each item by month will be required for the Facility to accurately interpret and analyze their progress with compliance.
	Summary of Monitor's Assessment: During the current review, the census for LBSSLC was 220 individuals. The Facility had four SLP positions allocated. At the time of the onsite review, the Habilitation Therapy Department had three SLPs employed. A fourth SLP had been hired, and would begin her employment in April 2012. The SLPs attended appropriate continuing education courses. During the last review, it was reported that no individuals received direct therapy. Similarly, at the time of this most recent review, none of the individuals at LBSSLC received direct therapy from a SLP. The Monitoring Team is hopeful that the addition of the fourth SLP will result in SLPs having additional time to provide direct therapy to individuals to enhance their skills in the use of their AAC system(s). SLPs were working in collaboration with psychologists to develop skill acquisition programs for the self-administration of medication. The collaboration between the SLPs and the psychologists demonstrated forward movement toward compliance within this section. However, a review of SLP assessments and PBSPs did not show collaboration between psychologists and SLPs. Based on documentation provided, 90 of the 220 (41%) individuals at LBSSLC had an augmentative/alternative communication (AAC) device. However, individuals' Speech Language (SL) assessments completed from 2008 to 2011 were completed prior to the most current revision of the SL assessment template. As a result, these assessments might not have included an AAC comprehensive assessment. It will be necessary for an audit to be completed of individuals' assessments and/or AAC consultations during these years to determine whether or not these individuals' assessments contained a comprehensive AAC assessment. Fourteen of the 22 individuals' ISPs (64%) in Sample R.1 had action steps and/or training objectives to develop individuals' skills for functional communication skills with the use of their AAC systems. This was a positive advancement in the integration of individuals' ACC systems into their ISPs. The NEO Follow-Up AAC Competency Drill had 11 tasks that required staff demonstration and/or verbal explanation. This drill could be individualized for an individual's AAC system. The demonstration drill met the standard of competency-based training, because it required staff to demonstrate their knowledge and skills. The development and implementation of core communication competencies for new employees was a positive development. However, as the Facility recognized a plan had not yet been developed for the completion of competency-based training for veteran staff on either the foundational communication skills or individual-specific plans and equipment.

	The Facility had formed a Communication Committee. The Committee acknowledged the "reality of communication devices not being utilized in individuals' homes" as a major concern. The Committee agreed to start with the basics by ensuring that equipment/tools were present in the home and in working order. The committee approved an AAC check-off tool. It was agreed that the 10 a.m. to 6 p.m. shift staff would be responsible for the completion of this form to verify AAC devices were present in the home, clean, and in good working order. The Residential Coordinator would contact the HT department for any corrections needed to devices. The committee decided to pilot this process in the Elm residence. At the time of the Monitoring Team's review, the results of this pilot were not yet available. It was positive that the Facility had begun to actively address this issue, because the Monitoring Team's observations continued to identify individuals who did not have their AAC devices with them, or staff were not assisting them to use the devices.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	The Monitoring Team's samples for Section R were as follows: ▪ Sample R.1 – 22 of 93 individuals who had AAC systems (24%) including: Individual #20, Individual #239, Individual #277, Individual #179, Individual #1, Individual #60, Individual #56, Individual #131, Individual #254, Individual #135, Individual #53, Individual #25, Individual #313, Individual #250, Individual #26, Individual #238, Individual #45, Individual #283, Individual #232, Individual #146, Individual #260, and Individual #140; ▪ Sample R.2 – two of three individuals newly admitted to LBSSLC (67%), including: Individual #57 and Individual #31; ▪ Sample R.3 – 18 of 139 individuals with Positive Behavior Support Plans (13%), including: Individual #135, Individual #45, Individual #250, Individual #254, Individual #25, Individual #232, Individual #277, Individual #131, Individual #140, Individual #239, Individual #26, Individual #31, Individual #273, Individual #1, Individual #146, Individual #179, Individual #20, and Individual #60; and ▪ Sample R.4 – 24 of the total census of 220 individuals (11%), including: Individual #20, Individual #239, Individual #277, Individual #179, Individual #1, Individual #60, Individual #260, Individual #56, Individual #131, Individual #31, Individual #273, Individual #254, Individual #135, Individual #53, Individual #25, Individual #313, Individual #250, Individual #26, Individual #238, Individual #45, Individual #283, Individual #232, Individual #146, and Individual #140. In assessing its progress for Section R.1, the Facility indicated that since the last review, the following self-assessment activities were initiated related to this requirement of the Settlement Agreement: ▪ The Director of HT hired a SLP and she was scheduled to begin employment in	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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April 2012.
▪ The Director of HT reviewed continuing education spreadsheets for the three SLPs to evaluate if a minimum of six hours of training in specialized areas had been completed. The results indicated that three of three SLPs attended a minimum of six hours of training in the past quarter. However, the Monitoring Team found one of the SLPs did not meet these criteria as discussed below.

<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>
During the current review, the census for LBSSLC was 220 individuals. The Facility had four SLP positions allocated, which was one less SLP position from the previous review. At the time of the onsite review, the Habilitation Therapy Department had three SLPs employed. The combined SLP caseloads resulted in a total of 225 individuals that exceeded the current census of LBSSLC. Based on the documentation provided, the following chart represents the caseload of the Facility SLPs, including current therapy vacancies:

<table>
<tr><th>Speech Language Pathologists</th><th>Current Caseload</th></tr>
<tr><td>SLP #1</td><td>PNMT Co-Coordinator, supported 38 individuals in 504 W and 504 E</td></tr>
<tr><td>SLP #2</td><td>Supported 106 individuals in residences 513, 514, 523, 525, 526, 527, and 528</td></tr>
<tr><td>SLP #3</td><td>Supported 81 individuals in residences 515, 516, 517, 518, 520 and 521</td></tr>
<tr><td>SLP #4</td><td>Position vacant, expected to be filled in April 2012</td></tr>
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Based on interview and review of documentation, an additional SLP had been hired and was expected to begin employment in April 2012. The addition of a fourth SLP should lower the caseloads for SLP #2 and SLP #3. The lower caseloads (i.e., approximately 60 individuals) should provide a manageable caseload.

To move forward in achieving compliance in Section R, SLPs should be more actively engaged in the provision of direct and indirect supports as well as being active participants on the individuals' interdisciplinary teams. For example, SLPs attended 14 of 24 (58%) individuals' annual ISP meetings in Sample R.4. A total of 22 of these individuals had AAC devices. Two individuals (i.e., Individual #273 and Individual #31) did not have AAC devices. However, based on documentation the Facility provided, Individual #273 and Individual #31 had severe language deficits. These individuals had
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		specific communication needs and would have benefited from a SLP attending their annual planning meeting. The absence of an SLP during an annual ISP meeting negatively impacted the discussion of an individual's communication potentials, and the successful integration of an individual's functional communication needs into the ISP. <u>Continuing Education</u> Attendance sheets and continuing education certificates of completion were submitted for the following courses completed since the Monitoring Team's last on-site review: ▪ On 9/29/11, SLP #1 and SLP #2 attended Power of Access Introduction; ▪ From 10/12/11 to 10/14/11, SLP #1 and SLP #2 attended Issues in Evaluation and Treatment of Individuals with Developmental Disabilities/Texas Annual Habilitation Therapy Conference. Multiple continuing education courses were presented during the annual HT Conference; ▪ On 11/16/11, SLP #1, SLP #2, and SLP #3 attended Switch Progression – A Road Map; ▪ On 2/13/12, SLP #2 attended Asperger's Syndrome; and ▪ On 2/17/12 SLP #1 and SLP #2 attended Children Who Struggle to Speak: The Kaufman Speech to Language Protocol. The SLPs attended appropriate continuing education 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, 90 of the 220 individuals at LBSSLC had an AAC device(s). A list provided by the Facility, updated 2/13/12, identified 140 individuals with severe and/or profound co-existing language deficits. Seventy-six of these individuals had AAC devices, but 64 of these individuals did not have AAC devices. However, as is discussed in further detail below with regard to Section R.2, a new assessment format had been developed. Given that it was not clear that these 64 individuals had been properly assessed regarding AAC devices using the old assessment format, the Director of HT, in collaboration with the SLPs, should determine if re-assessment of these 64 individuals with identified severe and/or profound co-existing language deficits is necessary to determine their current need for a functional AAC system. During the last review, it was reported that no individuals received direct therapy. Similarly, at the time of this most recent review, none of the individuals at LBSSLC received direct therapy from a SLP. The Monitoring Team is hopeful that the addition of the fourth SLP will result in SLPs having additional time to provide direct therapy to	

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		individuals to enhance their skills in the use of their AAC system(s). On a positive note, SLPs were working in collaboration with psychologists to develop skill acquisition programs. For example, Individual #179's ISP, dated 10/24/11, noted: "The Home Psychologist and SLP will work together to determine most appropriate communication program for [Individual #179] and then write a SAP [skill acquisition program]." A HT consultation, dated 11/10/11, reported the collaboration between a SLP and a psychologist in the development of a SAP for a self-administration of medications (SAMS) program. In addition, Individual #1's, HT Consultation also noted collaboration with the SLP and behavior analyst in the development of a SAMS program. The Facility SLPs and psychologists should continue to find opportunities to co-author SAPs to promote skill development and functional communication. The collaboration between the SLP and the psychologist demonstrated forward movement toward compliance within this section. The Facility's Self-Assessment indicated that it was not in compliance with this provision of the Settlement Agreement. This was consistent with the Monitoring Team's findings. The Facility self-assessment results stated: "this provision is not in substantial compliance due to have [two] positions vacant for the last [six] months." It should be noted the achievement of substantial compliance within this section extends beyond having filled SLP positions. The SLPs should be attending annual ISP meetings for individuals with communication deficits to provide their clinical expertise in the integration of an individual's AAC devices in their daily schedules, advocating for their AAC systems to be embedded in multiple SAPs, providing their expertise to IDT members in the development of SAPs, and providing direct therapy as appropriate.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	In assessing its progress for Section R.2, the Facility indicated that since the last review, the following self-assessment activities were initiated related to this requirement of the Settlement Agreement: ▪ The Director of HT reviewed the Speech Language Assessment Master Plan to evaluate if assessments were being completed per established priority for individuals with behavioral supports. The results indicated evaluations were being completed, but these results were based on pre-established criteria and did not consider the behavioral risk rating. This was an important finding for the Facility to identify. However, no further information was presented to indicate whether or not the SL assessments were audited for quality and adhered to the State-established content guidelines. ▪ The Director of HT reviewed the AAC spreadsheet to evaluate if systems were provided to individual who were ranked as high priority and identified to benefit from a system. The review indicated AAC systems had been provided to such individuals. However, the Monitoring Team did not find an audit of a	Noncompliance

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		spreadsheet to be sufficient to determine whether or not all individuals in need of an AAC system had been provided an AAC system. The audit should include a quality review of SL assessments to verify that individuals had been adequately assessed to determine their need for an AAC system. ▪ Based on the information provided, the Director of HT and the Director of Psychology planned to review documentation for individuals at high priority to verify collaboration between a SLP and a psychologist in development of a SAP, that training was provided to the individual, that staff competency-based training had been provided, that a monitoring plan had been established, and that the plans was integrated into the ISP. The current audit results indicated this system had not been developed and implemented. This collaborative effort between the two Directors was positive. The development of this system should provide significant traction in moving forward with compliance within this section. ▪ The Director of HT planned to review the assessment audit log to evaluate the presence of key elements of the assessment. The results indicated a new Speech Language assessment template had been established, but the audit tool had not been developed and implemented. Although based on the limited information provided, it was not clear precisely what the Facility's intent was with regard to this audit, the development and implementation of a SL assessment audit tool should not only review the presence of an assessment's key elements, but indicators also should be developed to assess quality. <u>All individuals in need of AAC are identified as being in need of AAC.</u> Based on documentation provided, 90 of the 220 (41%) individuals at LBSSLC had an augmentative/alternative communication device. There was a slight increase in the percentage of individuals with AAC systems as compared with the last review, which was 36% of the census. A review of the Master Communication Plan noted that multiple individuals' SL assessments were completed in 2008, 2009, and 2010. A total of 25 of the 220 individuals' SLs assessments (11%) were completed in 2008. The Master Communication Plan noted their "next update/evaluation" would occur in 2013. Twenty-seven individuals' assessments (12%) were completed in 2009. Their next update/evaluation would occur in the 2014. Twenty-nine individuals' assessments (13%) were completed in 2010, and their next projected update was in 2015. The Facility self-assessment noted the development of a new Speech Language assessment template. However, individuals' SL assessments completed from 2008 to 2011 were completed prior to the most current revision of the SL assessment template. As a result, these assessments might not have included an AAC comprehensive assessment. The Director of HT should initiate an audit of individuals' assessments and/or AAC consultations during these years to determine whether or not these individuals' assessments contained a comprehensive AAC assessment. The audit should determine	

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		whether or not all individuals in need of an AAC system have received an AAC system(s). The Facility submitted a new revised Speech Language assessment format. The Facility SL format did not include, risk levels, medications/precautions, and communication history. These headings were present in the State-established SL assessment format. . The new revised Facility assessment did not incorporate the State-established content guidelines under the assessment headings. The Facility SL assessment format should integrate risk levels, communication history, and medications/precautions headings, as well as the content guidelines provided in the State-established SL assessment format. A SL update format/template was not submitted in response to the document request. However, nine individuals in Sample R.4 had received an SL Update (i.e., Individual #250, Individual #283, Individual #254, Individual #25, Individual #238, Individual #232, Individual #239, Individual #1, and Individual #146). The content of the SL update differed from assessment to assessment. For example, Individual 25's SL Update, dated 3/25/11, included the headings of consults, augmentative/alternative communication, clinical impressions, and recommendations. The headings in Individual #232's SL Update, dated 7/7/11, were receptive/expressive language, augmentative/alternative communication and assistive technology, clinical impressions, and recommendations. The SL Updates did not consistently follow the new SL assessment template. The updates reviewed did not address an assessment of risk levels, analysis of findings to provide a rationale for recommendations, measurable outcomes, monitoring schedule, and/or factors for community placement. No Facility policies and/or procedures addressed the SL assessment and/or update. The Director of HT should integrate the State-established SL assessment guideline content in the Facility SL assessment formats to support a consistent approach to the completion of SL assessments, and related policies and procedures should be developed. The individuals in Sample R.1 had either a completed SL assessment or an update. A review of 24 individuals' SLP assessments in Sample R.4 found: ▪ Nine of the 24 individuals had a SL Update (i.e., Individual #250, Individual #283, Individual #254, Individual #25, Individual #238, Individual #232, Individual #239, Individual #1, and Individual #146). The following was noted: o Nine of nine assessments (100%) were dated as completed prior to the annual ISP. o Four of the nine individuals' SLPs (44%) attended the annual ISP. o None of the nine assessment updates (0%) assessed their risk levels. ▪ Fifteen of the 24 individuals had an SL assessment (i.e., Individual #135, Individual #45, Individual #313, Individual #277, Individual #131, Individual #56, Individual #53, Individual #140, Individual #26, Individual #31, Individual	

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		#273, Individual #179, Individual #20, Individual #260, and Individual #60). The following was noted: o Fourteen of the 15 individuals' assessments (93%) were dated as completed prior to the annual ISP. Individual #131's assessment was signed and dated after the annual ISP. o Nine of the 15 individuals' SLPs (60%) attended the annual ISP meeting. o One of the 15 individuals' OT/PT updates (i.e., Individual #62) (7%) adequately addressed their medium and high-risk levels. Generally, the updates did not adequately address an individual's risk levels that required supports from SLPs. The updates did not describe how services and supports would mitigate risks, provide rationales for services and supports, discuss the efficacy of the interventions, and present individual-specific triggers that would alert staff to a change in status, especially for those individuals at high risk for challenging behaviors. <u>All people have received a communication screening or assessment within 30 days of admission, readmission, or change in status.</u> Since the Monitoring Team's last onsite review, three individuals had been admitted to LBSSLC. A review of two individuals' SLP assessments in Sample R.2 found: ▪ Two of the two newly admitted individuals (100%) had received a SLP assessment within 30 days of admission. ▪ None of the two individuals (0%) had received an adequate SLP assessment to assess significant medical issues and health risk indicators, as they related to the SLP-related risk areas, in a clinically justified manner. Within 30 days of admission, IDT members were responsible for completing a risk assessment to determine areas of risk. The SLP assessment should provide an assessment of risk factors following the content of the SLP risk level guidelines. The SLP assessment information should assist the IDT in the completion of an individual's Integrated Risk Rating Form, and the development of the Risk Action Plan(s). <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> None of the 220 individuals (0%) living at LBSSLC received direct speech therapy. The SL assessment might have recommended SAPs, but there was not consistent carry through for development and implementation in the individual's ISP. Additional work was needed to move toward substantial compliance. Based on the records reviewed of individuals with AAC devices and/or individuals with behavioral issues with a need for replacement behaviors related to communication, the SLPs should	

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		increase the number of individuals receiving direct and indirect therapy supports. As stated above, none of the 90 individuals with prescribed AAC devices (0%) received direct support from a SLP. In addition, the SLPs should continue to work collaboratively with psychologists and other IDT professionals to develop and implement SAPs to support skill development in functional communication. The HT Department should develop protocols that include, at a minimum, the following: ▪ Timeframes for development and implementation of direct and indirect therapy plans; ▪ Format for direct and indirect therapy plans; ▪ Integration of direct and indirect therapy plans into an individual's ISP to support multiple opportunities to practice new and learned functional communication skills; ▪ Embedding skills learned in direct therapy in skill acquisition programs and daily schedules, as appropriate; ▪ Format for monthly progress notes that documents justification for initiation, continuation or discontinuation of direct therapy; ▪ Format for quarterly progress notes for provision of indirect supports; and ▪ Process for implementing change in an individual's direct therapy plan. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. Communication programs are integrated in the PBSP as indicated.</u> A review of 18 individuals with PBSPs in Sample R.3 found: ▪ Three of the 18 individuals' SL assessments (17%) (i.e., Individual #45, Individual #239, and Individual #179) documented collaboration between the speech language pathologist and psychologist in the development of the PBSP. The remaining 15 individuals' SL assessments stated an individual had a PBSP. The SL assessment should document the collaboration between the SLP and psychologist in the analysis of how the individual's communication issues potentially impact the individual's behavioral concerns. In addition, based on the individual's strengths and needs and as appropriate, the SLP and psychologist should collaborate on the development and implementation of SAPs to support functional communication skill development. Such training should occur in a variety of daily activities in multiple environments. In the previous report, the Monitoring Team noted that no procedures were in place to define the collaboration between SLPs and psychologists on the development and implementation of PBSPs. In the Facility's Action plan, an action step for Section R.2 noted: "Speech therapist will interface with the home psychologist to collaborate in the development of programs and provision of services." The results indicated that the system had not been developed and implemented. However, the Monitoring Team's	

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		review of individuals' SLP assessments and PBSPs did not substantiate that SLPs and psychologists had collaborated in the development of services and supports. The Facility's action plans did not include the development of a policy and/or procedure to provide guidelines to SLPs, psychologists, and related IDT members in the development, integration, and implementation of communication services and supports. Once Facility policies are established, SLP assessments and PBSPs should be audited to verify compliance with Facility policy and/or procedures. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> The Facility continued not to have any policy to address therapists' responsibilities for the provision of communication supports, which was noted in the previous report. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the ISP.</u> A review of 22 individuals' ISPs with prescribed AAC systems in Sample R.1 found: ▪ Fourteen of the 22 individuals' ISPs (64%) (i.e., Individual #45, Individual #313, Individual #250, Individual #25, Individual #238, Individual #232, Individual #277, Individual #56, Individual #53, Individual #26, Individual #1, Individual #146, Individual #179, and Individual #60) had action steps and/or training objectives to develop individuals' skills for functional communication through the use of their AAC systems. This was a positive advancement in the integration of individuals' ACC systems into their ISPs. <u>AAC devices are portable and functional in a variety of settings.</u> A review of 22 individuals' records with prescribed AAC systems in Sample R.1 found: ▪ Based on a review of individuals' SL assessment, 22 of the 22 individuals' AAC devices (100%) were designed to be functional and used in a variety of environments. The Monitoring Team's observation of two individuals within this sample (i.e., Individual #239 and Individual #135) noted that they did not have their devices with them in the workshop. Based on an interview with the SLPs, a major concern reported was staff's noncompliance with ensuring individuals used their AAC systems and had them available in multiple environments. The Communication Committee, which had been established to seek solutions to increase the utilization of individuals' AAC systems, also had raised this concern. The first focus of the Committee was to initiate a pilot project in one residence. The goal was to ensure communication devices were present in the residence, and were clean and in working order. The Facility	Noncompliance

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		understood there was a problem and had begun to take steps to resolve the problem of individuals not utilizing their devices. ▪ Nineteen of the 22 individuals' PNMPs (86%) provided additional written and pictorial staff instructions for an individual's AAC system(s). The SLPs were to be commended for developing these instructions. However, the instructions should provide additional detail for staff to understand how to use the device and engage the individual with the device. ▪ In addition, staff had not received competency-based training and performance check-offs to demonstrate their competency with individuals' AAC systems. As noted below, competency-based training and performance check-offs for staff should be provided to enhance staff's skills in assisting individuals to increase the use of their devices. The Monitoring Team's observations noted that individuals with AAC systems did not have their systems available to and/or with them. For example, Individual #135 and Individual #239 did not have their devices with them in the workshop. During an observation in Lilly, Individual #146's AAC system was in his backpack and consequently, he and his staff were not using it. Furthermore, as discussed in further detail with regard to Section R.4, a review of monitoring forms for individuals in Sample R.1 documented that individuals' systems were "not in use." Additional work needs to be done to ensure AAC devices were available and being used by individuals in a variety of settings. <u>Staff are trained in the use of the AAC device.</u> A review of competency-based training records for the individuals in Sample R.1 indicated the following: ▪ Eleven of the 22 individuals' staff (50%) (i.e., Individual #250, Individual #283, Individual #238, Individual #131, Individual #56, Individual #53, Individual #239, Individual #26, Individual #1, Individual #46, and Individual #20) had competency-based training and performance check-offs on communication. o Seven of the 11 individuals' staff (i.e., Individual #238, Individual #60, Individual #146, Individual #1, Individual #239, Individual #26, and Individual #53) had completed competency check-offs on communication as part of NEO. The NEO Follow-Up AAC Competency Drill had 11 tasks that required staff demonstration and/or verbal explanation. This drill could be individualized for an individual's AAC system. The demonstration drill met the standard of competency-based training, because it required staff to demonstrate their knowledge and skills with an individual's AAC device. An additional NEO Follow-Up AAC Competency Drill was a written test that did not require demonstration.	

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		o Four of the 11 individuals' staff (i.e., Individual #56, Individual #283, Individual #20 and Individual #250) completed individual specific competency-check offs. The individual-specific competency-checks required staff to demonstrate multiple tasks to achieve competency. ▪ Twenty-seven staff completed AAC/AT Equipment Competencies for Sign/Picture Daily Visual Schedule for Individual #20; ▪ One staff completed Picture Communication Book Competencies, VOCA Competencies, and Follow-up Competency Drill for Individual #250; ▪ Fifteen staff completed VOCA Competencies for Individual #283; and ▪ Five staff completed AAC Communication Button Competencies for Individual #56. The development and implementation of core communication competencies for new employees was a positive development. As noted in the Facility's Self-Assessment activities, the Director of HT and the SLPs should develop and implement a plan to provide competency-based training and performance check-offs for veteran staff. This should include core communication competencies as well as individual-specific competencies for individuals' AAC systems. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
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	In assessing its progress for Section R.4, the Facility indicated that since the last review, the following self assessment activities were initiated: ▪ The Director of HT and/or designee reviewed AAC monitoring for the presence of individuals' communication devices in multiple settings and to determine whether it was being utilized. The Facility's Self-Assessment indicated that monitoring had only recently begun, and sufficient data were not available to evaluate. As discussed below, the Monitoring Team's review of AAC monitoring forms for individuals in Sample R.1 identified multiple concerns. ▪ Action steps two through five referred to a review of the monitoring database to evaluate if monitors were compliant in monitoring assignment, required documentation was submitted on time, individual's AAC systems were available in a variety of settings, if systems were readily available and in use, and actions were taken to resolve problems. However, the Facility's Self-Assessment noted that the monitoring database had not been developed and implemented. The	Noncompliance

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	available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	development of a monitoring database was a constructive move forward in allowing the Facility to analyze multiple types of data as defined in the action steps. The Monitoring Team's review of current AAC monitoring forms indicated significant non-compliance with staff ensuring individuals' AAC were in use. <u>Monitoring system is in place that tracks the presence of the ACC devices, working condition of the AAC devices, the implementation of the device, and effectiveness of the device.</u> As stated in the Monitoring Team's previous report, no monitoring policy and/or procedures defined the monitoring system for individuals' AAC systems. At the time of this review, no policy and/or procedures had been developed. However, the Facility action plan for Section R.4 noted the development and implementation of a plan to ensure the use, availability, and condition of adaptive/assistive supports, including alternative/augmentative communication systems was "in process." The Presentation Book for Section R contained meeting minutes for two meetings of the Communication Committee. The first meeting of the workgroup occurred on 2/29/12. The minutes identified the "reality of communication devices not being utilized in individuals' homes" as a major concern. It was positive that the Facility acknowledged the problem with individuals' AAC systems not being readily available and functioning properly. The Monitoring Team's observations identified some individuals with prescribed AAC systems that did not have their systems with them, and/or the systems were not being used (e.g., Individual #239, Individual #146, and Individual #135). The Committee agreed to start with the basics by ensuring that equipment/tools were present in the home and in working order. The Committee approved an AAC check-off tool. It was agreed that the 10 a.m. to 6 p.m. shift staff would be responsible for the completion of this form to verify AAC devices were present in the home, clean, and in good working order. The Residential Coordinator would contact the HT department for any corrections needed to devices. The Committee decided to pilot this process in the Elm residence. If the pilot were successful, it would be replicated in the entire Facility. However, no data was presented to report on the progress of the Elm pilot. The Communication Committee should continue to develop and implement a system that supports and increases staff compliance with individuals' AAC systems. A review of monitoring form documentation for the 22 individuals with AAC systems in Sample R.1 found: ▪ Twenty-one of the 22 individuals' records (95%) noted AAC Individual Equipment Monitoring Forms had been completed. Individual #20's AAC system had not been monitored. However, the AAC monitoring was not adequate. The following concerns were noted:	

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		o Individual #283 was the only individual whose AAC equipment was monitored on the revised form that was discussed in the previous report. All other individuals were monitored using the inadequate AAC form, which placed all equipment in one box. If the monitor marked the equipment as not present, if was not possible to discern if all equipment and/or just one piece of equipment was missing. Monitors should utilize the revised AAC form. o Over the past six months, there did not appear to be a consistent approach to AAC monitoring. For example, 11 individuals' systems were monitored one time (i.e., Individual #25, Individual #232, Individual #277, Individual #131, Individual #140, Individual #239, Individual #60, Individual #238, Individual #56, Individual #260, and Individual #283), six individuals were monitored two times (i.e., Individual #135, Individual #45, Individual #250, Individual #54, Individual #1, and Individual #313), and four individuals were monitored three times (i.e., Individual #26, Individual #146, Individual #179, and Individual #53). No rationale was provided. o Individuals' AAC systems were not consistently listed on monitoring form [i.e., for Individual #277 (i.e., single-message voice output communication aide), Individual #146 (i.e., dining room U-shaped picture/word/sign communication placement), Individual #56 (i.e., communication button), Individual #53 (i.e., mealtime voice output communication aide), and Individual #260 (i.e., five inch disc with object)]. o Identified concerns were not resolved on the current monitoring form and/or subsequent forms (i.e., Individual #131, Individual #140, Individual #60, Individual #238, and Individual #283) o The AAC monitoring forms were completed in residences. Monitoring of AAC systems should occur in multiple environments to document that individuals' AAC systems are available, in good working order and in use. As recommended in the previous report, the Facility should incorporate the following in an AAC equipment monitoring policy and/or procedures: ▪ 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	

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		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, AAC monitoring was not occurring in multiple environments. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> At this time the HT Department was not conducting validity checks. The Facility's Self-Assessment indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	

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

1. SLPs should be more actively engaged in the provision of direct and indirect supports, as well as being active participants on individuals' interdisciplinary teams. (Section R.1)
2. The Director of HT should finalize and implement a SL assessment audit tool. The audit of individuals' assessments and/or AAC consultations completed between the years of 2008 and 2011 should determine whether or not these individual's assessments contained a comprehensive AAC assessment. The audit also should be used to determine whether all individuals in need of an AAC system have received an AAC system(s). (Section R.2)
3. The Director of HT in collaboration with the SLPs should update the SL assessment format to integrate risk levels, communication history, and medications/precautions headings, as well as the content guidelines provided in the State-established SL assessment format. (Section R.2)
4. The Director of HT and SLPs should review the current department guidelines for individuals who have a PBSP to further define how collaboration between SLPs and psychologists will be implemented and documented. (Section R.2)
5. The HT Department should develop a policy to define the expectations for the development and implementation of direct and indirect therapy programs. These protocols should include, at a minimum, the following:
    a. Timeframes for development and implementation of direct and indirect therapy plans;
    b. Format for direct and indirect therapy plans;
    c. Integration of direct and indirect therapy plans into an individual's ISP to support multiple opportunities to practice new and learned functional communication skills;
    d. Embedding skills learned in direct therapy in skill acquisition programs and daily schedules, as appropriate;
    e. Format for monthly progress notes that documents justification for initiation, continuation or discontinuation of direct therapy;
    f. Format for quarterly progress notes for provision of indirect supports. (Section R.2)

6. The HT Director and SLPs should explore ways to increase the number of individuals who receive direct and indirect speech therapy. (Section R.2)
7. The SLPs should partner with IDT members to provide their clinical expertise by co-authoring SAPs related to communication. (Section R.3)
8. The Speech staff in the Habilitation Therapies Department should complete the competency-based training and performance check-offs for core communication that were developed for NEO with veteran staff. In addition, veteran staff also should complete competency performance check-offs for individual-specific strategies for AAC systems. (Section R.3).
9. The Communication Committee should continue to develop and implement a system that supports and increases staff compliance with individuals' AAC systems. (Section R.4)
10. As recommended in the previous report, the Facility should incorporate the following in an AAC equipment monitoring policy and/or procedures:
    a. Definition of monitoring process to ensure all communication equipment is available, functioning, and effective for the individual;
    b. Monitoring forms should include instructions for individual monitoring indicators to support consistency and provide a platform to test 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)
11. The HT Department should audit equipment-monitoring forms to ensure compliance with established guidelines. (Section R.4)
12. The monitoring schedule for AAC systems should be formalized to ensure monitoring occurs in multiple environments to reinforce individuals' utilization of their devices in a variety of environments. (Section R.4)
13. The Facility should develop and implement the audit tools, databases, and systems described in its Self-Assessment for Sections R.1 through R.4. (Facility Self-Assessment)
14. The Facility should develop a unified system to present data from the self-assessment activities in a meaningful way to enable the monitoring results to be easily analyzed and trends identified. The presentation of data should include the total population being reviewed (N), and the sample of the population (n) to produce a percent sample to indicate the relevance of compliance scores. (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: o **Review of Following Documents**: o Section S Presentation Book – developed by Tracey Snow Murphy, Director of Residential Services; o For Section S.1, Functional Skills Assessments (FSA), Personal Focus Assessments (PFA), Positive Assessment of Living Skills (PALS), Individual Support Plans, Skill Acquisition Plans (SAP), and SAP data, for the last three months, as available, for: Individual #240, Individual #124, Individual #237, Individual #192, Individual #104, Individual #184, Individual #306, Individual #3, and Individual #31; o For Section S.1, Functional Skills Assessments, Personal Focus Assessments, Positive Assessment of Living Skills, Individual Support Plans, and Dental Desensitization Plans, as available for: Individual #306, Individual #156, Individual #190, Individual #318, Individual #222, Individual #306, Individual #23, and Individual #270; o For Sample S.2, Functional Skills Assessments, Personal Focus Assessments, Positive Assessment of Living Skills, Individual Support Plans, and Vocational Assessment, as available for: Individual #57, Individual #31, Individual #240, Individual #124, Individual #237, Individual #190, Individual #271, Individual #306, Individual #35, Individual #156, Individual #115, Individual#6, Individual #139, and Individual #184; and o For Section S.3, Skill Acquisition Plans, as available for: Individual #240, Individual #124, Individual #237, Individual #192, Individual #104, Individual #184, Individual #306, Individual #3, and Individual #31. o **Interviews with**: o Jim Forbes, Director of Behavioral Services; and Carolyn Milton, Assistant Director of Behavioral Services, on 3/19/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and Bob Robbins, QA/QI, on 3/20/12; o Mary Ortiz, Director of Competency Training and Development, on 3/20/12; o Lola Walker, Qualified Developmental Disabilities Professional Coordinator; Marisol Gonzales, ISP Coordinator; Rodshadi Moore, Active Treatment Supervisor; Tracey Snow Murphy, Director of Residential Services; Sandra Kennedy, QDDP Educator; Jim Forbes, Director of Behavioral Services; and Carolyn Milton, Assistant Director of Behavioral Services, on 3/20/12; o Psychologists and Psychology Assistants, including Philip Kite, Raul Jamie Trevino, Joanna Molleca, Jody Ramos, Christina Sosa, Krista Leubner, Beckie Crawford, Jose Fragoso, Amber Flores, Melissa Faults, Lamecca Abduljaami, Brandi Jackson, and Nicole Holstein, on 3/20/12; o Tracey Snow Murphy, Director of Residential Services; and Marilyn Foster, Program Compliance Monitor, on 3/21/12;

	o Rodshadi Moore, Active Treatment Supervisor; Adrian Richardson, Active Treatment Coordinator; Kimmie Scott-McGiruder, Active Treatment Coordinator; and Erika Flores, Active Treatment Coordinator, on 3/20/12; o Rodshadi Moore, Active Treatment Supervisor, on 3/22/12; o Record review, assisted by Jody Ramos, Administrative Assistant, Behavioral Services, on 3/22/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and Texas Tech faculty and students, on 3/22/12; and o Laura Anciso, Director of Vocational and Day Programs; and Rosie Driver, Supportive Employment Coordinator, on 3/22/12. o **Observations of**: o ISP Meeting for Individual #259, on 3/20/12; o Psychiatric Clinic, on 3/21/12; o Staff training (of the PBSP) for Individual #271 at 514 S. Cedar, on 3/21/12; o Desensitization Committee Meeting, on 3/22/12; o Staff training (of the PBSP) for Individual #33 at 513 S. Cedar, on 3/21/12; o Behavior Support Committee Peer Review Meeting, on 3/22/12; and o Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the day and/or evening hours at the following sites: ▪ Birch (514), on 3/20/12; ▪ Elm (515), on 3/20/12; ▪ Aspen (513), on 3/20/12; ▪ Gym (512), on 3/20/12; ▪ Fir (516), on 3/21/12; ▪ Maple (517), on 3/21/12; ▪ Zinnia (528), on 3/21/12; ▪ Iris (527), on 3/22/12; and ▪ Tulip (526), on 3/22/12.
	Facility Self-Assessment: 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. Current reports indicated that the Director of Residential services as well as the Program Compliance Monitor conducted reviews using the self-assessment tool. According to verbal reports, the nature of these reviews was similar to the process previously described. However, the reviewers completed reviews together during the month of January 2012 to facilitate active discussion and revision while completing the tool. Verbal reports indicated that this process supported improved agreement between the raters. Although verbal reports indicated that monthly compliance data using this tool was collected, no scores were available for review. At the current time, it appeared that the Facility was unclear about the direction compliance monitoring was headed. That is, verbal reports indicated the potential inclusion of new quality indicators that might replace the current monitoring tool.

	The Facility had also developed a Self-Assessment with regard to Section S of the Settlement Agreement. The 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 Self-Assessment, LBSSLC indicated that it was not in noncompliance with Sections S.1, S.2, and S.3. These findings were consistent with the Monitoring Team's review. Items on the Self-Assessment appeared to target the number of SAPs completed, but not yet the quality of those developed. A similar approach was employed to examine the nature of staff training. However, the rubric utilized to examine staff competency was reported to be inadequate and under revision. Currently, inadequacy in the number of SAPs completed was self-reported. And, the lack of systems to monitor the quality of SAPs as well as of staff training also was reported. Items also targeted the completion of PFA, FSAs, and Vocational Assessments. Although the numbers of completed assessments were estimated, self-reports indicated that systems to adequately estimate the quality and timeliness of these assessments were not yet developed. Lastly, items of the Self-Assessment also appeared to examine the number and quality of trainers available to support training of new SAPs. Although a substantial number of staff had been trained, it was reported that systems to verify competence were inadequate.
	Summary of Monitor's Assessment: The Facility continued to make progress in the area of habilitation services in the development of improved skill acquisition programs (SAPs), including desensitization plans. This included the continued revision of the SAP format, including a revised data collection methodology. Plans reviewed adhered to this revised format, but concerns regarding the adequacy of the SAPs and data collection remained. Estimates of engagement continued to reflect less than desirable levels of engagement during brief onsite observations. Revisions in the methods used to estimate engagement as well as integrity of SAP implementation was underway, and appeared to require additional technical support and oversight to ensure their adequate development and implementation. Assessments, including Personal Focus Assessments, Functional Skills Assessments, and Vocational Assessments, continued to demonstrate concerns regarding their adequacy. Efforts were observed in improving and expanding the resources available to support training of direct support professionals in implementing active treatment, including SAPs. However, the Facility should ensure that these additional staff members are competent trainers. That is, they should be skilled at conducting competency-based training. The provision of formal skill programming in vocational and community-based settings remained a concern. This included the continued lack of improvement in opportunities for individuals in off-campus vocational settings.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Across the Monitoring Team's last several visits, progress had been noted in the area of habilitation services in the development of improved skill acquisition programs. This progress included revision of the SAP format, the development and training of a new curriculum (including PowerPoint slides, handouts, activity) targeting habilitation, training, education, and skill acquisition programs. In addition, efforts had been made to train Active Treatment Staff. At the time of the most recent review, similar progress was noted in continued revision of the SAP format, development of plans consistent with this new format, and continued training of staff to develop and train SAPs. During the Monitoring Team's earlier reviews, examination of sampled SAPs revealed that only a small number of plans had been written utilizing the revised SAP format. That is, only two of the eight individuals selected (this sample represented 26% of those with SAPs completed at the time) had SAPs that followed the most current SAP format. Of these new plans, it appeared that the most recently revised format was an improvement compared to previous programs, because the SAPs were more likely to contain the identified sections (and related content) necessary to support effective skill acquisition. However, consistent with previous findings, many of the SAPs sampled at that time 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 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. Since the Monitoring Team's last visit, according to documentation provided, the SAP format was slightly modified, and in November 2011, the campus-wide "rollout" of the new SAP process was initiated. To ensure the integrity of the newly developed SAPs, the Director of Behavioral Services developed the "Required Elements of Skill Acquisition Programs." It was described as a simple yet comprehensive guide for use by staff as they developed new SAPs. This tool was intended to assist developers in ensuring that all the critical and necessary elements of effective skill acquisition were included in the SAPs. Documentation indicated that in January 2012, psychologists were re-trained in the use of the revised SAPs, as well as in the use of this new self-monitoring tool. In addition, it appeared that changes consistent with revisions in the SAP format and	Noncompliance

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		process were integrated into New Employee Orientation (NEO). It should be noted, however, that the revised training curriculum that was provided for review appeared to be missing some important concepts, such as types of chaining (i.e., forward, backward, total task presentation), as well as specific information on the adopted prompting hierarchy. In addition, it was unclear to the Monitoring Team why information on Specific Program Objectives (SPOs) was still included in the training curriculum. Documentation indicated that multiple trainings were held at residential programs throughout November and December 2011 to train staff on the new SAP process. Based on documentation provided, it could not be determined whether or not all residential direct support professionals were trained. Indeed, it appeared unlikely, because training sessions did not appear to be held at Birch (514) or Iris (527). It was difficult to estimate the number of new SAPs developed since the Monitoring Team's last visit. This estimate might be an elusive target, because the format of the SAP had changed as it had evolved over time. Indeed, the current SAP format appeared slightly different from those previously reviewed, including the current use of a much different data sheet format. In an effort to examine the quality of current SAPs, a sample of completed plans from nine individuals (one SAP from each individual) who had an ISP meeting since the Monitoring Team's last visit were reviewed. Initially, the Monitoring Team had requested SAP documentation and related data for a much larger sample. However, out of the documentation reviewed for 25 individuals, SAPs were only provided for these nine individuals. Consequently, it was unclear if these nine reflected an accurate estimate of individuals with completed SAPs (36% of those reviewed), or if documentation was simply not provided. Documentation including ISPs, SAPs, and related data were reviewed for these nine individuals to examine whether or not they included components necessary for learning and skill development. Overall, the current review revealed that adequate critical elements were present in none (0%) of the SAPs reviewed. In other words, in all of the SAPs reviewed, critical elements were either missing or appeared inadequate. It should be noted, however, that the plans did appear improved compared to previously reviewed SAPs, and they all adhered to the new SAP format. Indeed, the new data sheet appeared to be a vast improvement. However, as indicated below, it was not consistently utilized. The following are the specific SAPs examined followed by a general review of the findings: ▪ Individual #240 (i.e., SAP targeting identification of law enforcement attire); ▪ Individual #124 (i.e., SAP targeting identification of emotion); ▪ Individual #237 (i.e., SAP targeting identification of healthy choices); ▪ Individual #192 (i.e., SAP targeting the use of an adapted switch); ▪ Individual #104 (i.e., SAP targeting holding sponges during self-care); ▪ Individual #184 (i.e., SAP targeting tolerance to tooth brushing);	

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		▪ Individual #306 (i.e., SAP targeting leaving a van); ▪ Individual #3 (i.e., SAP targeting money management); and ▪ Individual #31 (i.e., SAP targeting wearing shoes). In general, the SAPs reviewed appeared to closely adhere to a prescribed format (with the exception of data collection). In all of the SAPs reviewed, the materials needed for the SAP were adequately described. Often, however, the setting for training was not conspicuously prescribed (e.g., Individual #124). In addition, the behavioral objective was found to be vague (e.g., Individual #3 and Individual #124), inadequate (e.g., Individual #306), or inconsistent with mastery criteria (e.g., Individual #240). In other cases, the behavioral definition was not always conspicuous (e.g., Individual #192 and Individual #306) or appeared vague or incomplete (e.g., Individual #3 and Individual #237). Although all the plans had a task analysis, some appeared to be incomplete (e.g., Individual #240, Individual #306, and Individual #192), vague (Individual #3), and/or included inappropriate information, which, at times, included specific staff behavior and not specific individual responses to be trained (e.g., Individual #192, Individual #104, and Individual #184). In most cases, the opportunities to practice the skill appeared sufficient. Indeed, in some cases, it appeared that the amount of scheduled practice seemed to exceed what might be considered typical or practical (e.g., Individual #124 and Individual #237). In some cases, the cue or discriminative stimulus identified was not consistent with the prescribed format (e.g., Individual # 192), was unnecessarily prescribed within each step (e.g., Individual #184), or seemingly was not appropriate (e.g., Individual #3). Instructions following correct responding appeared adequate and typically involved the use of praise as a reinforcer. Unfortunately, only one plan appeared to utilize individualized and concrete reinforce(s) in addition to verbal praise (i.e., Individual #306). In many cases, the instructions following incorrect responding still appeared confusing, inadequate, or did not utilize differential reinforcement appropriately (e.g., Individual #192 and Individual #306). Only one of the SAPs conspicuously identified the type of chaining (i.e., forward, backward, total task) being utilized (i.e., Individual #124). Although the type of training would likely be apparent with further examination, the efficiency of training and implementation might be enhanced if it was conspicuously identified. In addition, the prompt hierarchy was not always conspicuously identified (e.g., Individual #192 and Individual #306), not prescribed (e.g., Individual #240), or was described inconsistent with the current SAP format (e.g., Individual #3 and Individual #192). And, in some cases, the prescribed completion of subsequent steps by staff following a targeted step for training made no sense (e.g., Individual #3 and Individual #184). Also, the mastery criteria appeared inconsistent across plans and not necessarily	

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		based on any identified rationale. Although for most plans, generalization strategies were adequate, maintenance strategies were often inadequate and did not specify monitoring criteria (e.g., Individual #104, Individual #3, Individual #124, and Individual #192) or contained inaccurate information (e.g., Individual #237). Lastly, the SAPs did not appear to be dated. Consequently, it was difficult to determine if data collection was collected consistent with implementation of the plan. Documentation was examined for the current sample of individuals to determine if the identified programs were based on individuals' needs as identified in the ISP, Functional Skills Assessment, Personal Focus Assessment, and/or psychological assessment. Based on this review, it appeared that needs related to the SAPs were identified in seven (78%) of the above individuals' ISPs. The exceptions were the ISPs for Individual #306 and Individual #240 (i.e., it should be noted that the ISP for Individual #306 was not available for review). Many of the reviewed SAPs identified the specific assessment (i.e., which identified the need or preference) that was the basis of the SAP. More specifically, six (67%) of the SAPs identified a specific assessment within the rationale section of the plan that was the basis for targeting the current skill. The exceptions were the SAPs for Individual #237, Individual #240, and Individual #124. Examination of psychological assessments revealed that selected SAPs were not identified or recommended in any (0%) of those assessments reviewed. The absence of this information in the psychological assessments was not necessarily unexpected. That is, the selected SAPs did not target responses (e.g., replacement behaviors) typically addressed in psychological assessments. However, because an increasing number of SAPs were expected to be developed targeting replacement behaviors, recommendations related to these SAPs will likely be found in this documentation in the future. Data related to SAPs also was requested, including the last three months of data for all SAPs requested. The nine individuals reviewed (same as those reviewed above) appeared to have a total of 30 SAPs (Individual #124 had four additional skill programs in the older SPO format that were not included in this review). At least one or more months of data was available for 23 (77%) of the SAPs. Of those, 20 (87%) utilized the new data collection format. Data sheets for each individual as related to the identified SAP (noted above) were reviewed, as available, and several concerns were noted: ▪ No data was available for Individual #104 and Individual #31. The previous data sheet format was utilized for Individual #237; ▪ Significant amounts of data was missing (e.g., February 2012 data for Individual #192, January 2012 data for Individual 184, and February 2012 data for Individual 306); ▪ Data was not collected as prescribed. That is, data was collected more frequently than indicated (e.g., January 2012 data for Individual #192, February 2012 data for Individual #184, February 2012 data for Individual #306, and	

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		February 2012 data for Individual #3). In some ways, this inconsistency was positive, because staff tended to collect more data than was prescribed; ▪ Staff appeared to inappropriately change the targeted step of the task analysis without first meeting the stated criterion (e.g., tooth brushing data in February for Individual #31); ▪ The required prompt levels were not recorded even though it appeared that trials were completed (e.g., January 2012 data for Individual #3); ▪ Generalization data did not appear to be collected as prescribed (e.g., January 2012 data for Individual #192; and February 2012 data for Individual #306, Individual #3, and Individual #31); ▪ Staff appeared to be recording prompting data on all steps for programs that appeared to be using forward chaining and not total task presentation, which the data appeared to reflect (i.e., Individual #192); ▪ The individual appeared to meet criteria on the first five trials and a subsequent change to maintenance trials did not occur as prescribed by mastery criteria (non-dated data sheet for Individual #240). This excelled performance questioned the adequacy of staff's assessment and validation of the task analysis prior to the implementation of the SAP. Consistent with findings of the Monitoring Team's previous reviews, the collection of skill acquisition data continued to be inadequate. However, data reviewed indicated that the new data collection format had only been in use for a few months. Indeed, most of the data provided was for two or less months. A sample of the dental desensitization programs was selected from those provided for review and examined to determine their quality. This review was similar to that completed for the SAPs as identified above. Five plans were selected representing approximately 16% of the total number of dental desensitization programs developed to date (i.e., at the time of the review, based on verbal report of the Director of Behavioral Services, there were 32 total plans written) – these included the plans for Individual #318, Individual #222, Individual #306, Individual #23, and Individual #270. The findings of the review were consistent with the examination of SAPs as reported above. More specifically, reviewed plans appeared adequate with regard to identified settings, schedules for training and opportunities to respond, and the description of necessary materials. In addition, plans utilized either praise or praise with supplemental concrete edible reinforcers following correct responding. In addition, most plans identified adequate discriminative stimuli as cues; although the behavior objectives could more clearly integrate discriminate stimuli in some plans (Individual #318 and Individual #222). However, inadequacies were noted with regard to insufficient behavioral objectives (Individual #222, Individual #306, and Individual #23) and inadequate task analysis (Individual #306, Individual #23, and Individual #270) in some plans.	

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		Instructions following incorrect responding appeared clearer and more consistent than on previously reviewed SAPs. However, as previously found, none of the plans conspicuously identified the type of chaining (i.e., forward, backward, total task) being utilized. In addition, the prompt hierarchy was not always conspicuously identified (Individual #306). The mastery criteria appeared inconsistent across plans and not necessarily based on any identified rationale. Although for most plans generalization strategies were adequate (except for individual #270), maintenance strategies in a few plans did not specify monitoring criteria (Individual #318 and Individual #222). Lastly, the desensitization plans did not appear to be dated. An additional sample of provided desensitization programs was selected from those provided for review and examined to determine if these programs were based on individuals' needs as identified in the ISP, functional skills assessment (FSA), and/or psychological assessment. Three plans were selected (i.e., Individual #306, Individual #156, and Individual #190). This represented approximately 10% of the total number of desensitization programs developed to date (based on verbal report of the Director of Behavioral Services). Examination of documentation provided revealed that two (67%) of the three individuals' desensitization plan appeared related to an identified need as evidenced within the ISP, FSA, and/or psychological assessment. However, there were concerns noted regarding the consistency between these plans and the assessments from which they were based. The following were the findings of this review: ▪ The nail desensitization program for Individual #306 did not appear to be identified as a need and/or recommended in the psychological assessment, or in the FSA. The ISP was not provided for review. The program indicated that: "according to this functional skills assessment [individual] needs assistance with nail care." This was accurate in that items 3.9 and 3.10 related to nail care were scored "manipulation," reflecting the need for full physical guidance. However, the functional skills assessment did not identify nail desensitization training as a need or as a recommendation. Indeed, the recommendation was for a "toileting program," which did not appear to be reflected in any skill program available for review. ▪ The dental desensitization program for Individual #156 was identified as a need in his ISP, dated 10/12/11, due to his combative behavior during dental procedures. However, this appeared somewhat inconsistent with the documentation in the PFA, dated 7/15/11, that indicated: "[individual] is compliant in going to the doctor/dental appointment if reinforcers are utilized." Also, this was not identified as a need or recommended in the current FSA. Consequently, it was unclear to the Monitoring Team what assessment provided the basis for the information in the ISP. ▪ The desensitization program, which targeted "waiting" for appointments, for Individual #190 was identified as a need and recommended within his ISP, dated	

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		4/4/11. This was due to his past unsafe behavior while at the dental clinic. However, the nature of this program did not appear to be consistent with the findings of the FSA, which identified more basic pre-requisite needs. That is, the current FSA indicated that he "…needs to allow staff to assist with grooming," and items related to dental hygiene reflected a need for hand-over-hand support for most steps involved in tooth brushing. The current dental desensitization plan, however, did not target these dental hygiene responses, but rather targeted "waiting" at dental appointments. The Monitoring Team recognized that the new Dental Desensitization Assessment process was not yet in place when this plan was developed, and, going forward, would likely see a revision of this plan that more closely addressed the pre-requisite skills identified as needs in the FSA. Given the above findings, it continued to be unlikely that the majority of skill acquisition programs, including desensitization programs, were currently promoting growth, development, and independence across most individuals served at LBSSLC. In addition, at the current time, based on verbal reports and documentation provided, the above changes noted with regard to the development, implementation, and monitoring of skill acquisition programs had not yet been integrated into formal LBSSLC policy. As similar to the Monitoring Team's previous 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. Engagement and Staffing Ratio Observations ***Location*** | ***Engaged*** | ***Staff-to-individual ratio*** Birch | 1:1 | 1:1 Elm | 2:5 | 1:5 Aspen | 2:4 | 2:4 Aspen | 4:6 | 2:6 Fir | 5:5 | 1:5	

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Maple	2:3	2:3
Maple	5:8	2:8
Zinnia	2:2	1:2
Zinnia	1:7	2:7
Iris	1:6	1:6
Iris	1:3	0:3
Iris	3:3	1:3
Tulip	2:5	2:5

According to collected data, during brief residential visits overall engagement was 53%. This reflected a decrease in the estimated level of engagement compared to the previously estimated level (70%) evidenced at the Monitoring Team's last visit. An engagement level of at least 75% would be a typical target for a facility like LBSSLC. Consistent with observations during the Monitoring Team's previous visits, the staff-to-individual ratios observed in some settings were concerning. Observations from the current visit suggested seemingly inadequate ratios at Iris, Fir, Maple, and Elm, which, in most cases, appeared to impair active engagement or participation in more structured opportunities for skill acquisition.

As noted in the Monitoring Team's previous reports, engagement was assessed utilizing the Active Treatment Monitoring/Coaching Tool. Active Treatment staff utilized this tool to ensure staff competence regarding maintaining acceptable levels of engagement in all residential settings. In the past, active engagement data had demonstrated the monthly completion of this tool across residences. Previous, estimates of monthly active treatment had ranged between 79 to 98%. Currently provided summary data from November through February 2012 indicated similar ranges. Although estimates reported for some programs in select months appeared somewhat lower. More specifically, engagement scores for some homes appeared inadequate. These included 515 (44% in November 2011), 523 (62% in December 2011, and 42% in January 2012), 525 (57% in January 2012), 526 (60% in January 2012), 527 (52% in January 2012), and 528 (44% in January 2012). Monthly active engagement meeting minutes (from February 2012) reflected active discussion and problem solving related to these low scores.

Recent verbal reports as well as documentation provided indicated qualitative revision in the Active Treatment Monitoring/Coaching Tool. The revised form, the Engagement Monitoring Form, included an estimate of engagement (using a three-minute interval), as well as similar items designed to assess availability of materials and staff efforts at appropriate and sufficient facilitation of engagement. This revision was reported to have recently occurred (in March 2012), and no data appeared to have been submitted related

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		to its implementation. This revised form appeared to be an improvement compared to the previous tool, because operational definitions and specific instructions were provided in addition to a structured format for estimating active engagement through direct observation. In addition, space on the form was provided for recording descriptions of needed coaching/training following monitoring. As the Facility initiates use of this tool, they are encouraged to be mindful of the importance of ensuring the integrity of the new measure by completing reliability checks across observers. Recent verbal reports and documentation provided also evidenced the completion of Program Observation Drills. These drills were completed to estimate staff knowledge and skills in implementing SAPs. Although, from the data provided, it was unclear how many total observation drills were conducted since the Monitoring Team's last visit. Summary data indicated that these were conducted between November 2011 and February 2012. Average monthly estimates across this time period ranged from 55% to 100%. It appeared that this observation format was recently revised as well. That is, a draft of the revised format was provided, and it appeared that items related to PNMPs and PBSPs were removed from the form and more specific questions related to SAPs were added. The Monitoring Team believes that this assessment would be improved if the format was more similar to actual skill plans and assessed staff's ability to actually implement specific instructional steps. That is, the format could be improved if it mirrored the integrated format currently being initiated for PBSPs (as discussed in more detail with regard to Section K.11). For example, assessing whether or not: 1) staff utilized the correct discriminative stimulus; 2) staff identified the correct training step; 3) staff responded correctly following individual error; 4) staff utilized the appropriate. prompt hierarchy; and 4) staff documented performance accurately, etc. Lastly, verbal reports from the Director of Vocational and Day Programs and the Coordinator of Supportive Employment, as well as documentation the Facility provided indicated no substantial changes in regard to number of individuals in vocational programs and on-campus workshops. Data currently reflected no individuals in off-campus supported employment. However, the number of individuals served in the on-campus Client Worker program had increased significantly (i.e., from approximately 11 to 25 individuals supported). Unfortunately, the number of individuals involved in off-campus Enclave work decreased significantly (i.e., from approximately nine to four individuals supported). In addition, the number of individuals employed part-time, either on-campus or off-campus, also decreased since the Monitoring Team's last visit. Lastly, it appeared that one additional individual was placed within a competitive employment position. According to verbal reports, the primary remaining barrier to improving the number of individuals working within supported, enclave, or competitive employment positions	

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		was the continued effect of the poor economy. 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 as more and 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.	Consistent with the Monitoring Team's previous reports, minimal to no 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. As described in the Monitoring Team's previous reports, the Personal Focus Assessment had been implemented to facilitate the identification of individual goals and preferences, as well as the necessary subsequent assessments. In addition, the Functional Skills Assessment had been implemented 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 was selected of individuals who had ISP meetings since the Monitoring Team's last visit. A sample of 14 individuals was randomly selected, and assessments, including the ISP, PFAs, and/or FSA, as provided, were examined. Of the 14 individuals, documentation evidenced completion of PFAs for only 10 (71%) individuals. That is, PFAs were unavailable for four individuals (i.e., Individual #57, Individual #31, Individual #240, and Individual #35). Of those PFAs that were available, only six (60%) were completed within the last 12 months. The PFAs for four individuals were completed in excess of 12 months from the Monitoring Team's visit (i.e., Individual #115, Individual #6, Individual #271, and Individual #306). Of all the available PFAs (including those that were outdated), only six (60%) appeared to be adequately completed. More specifically, the PFAs for four individuals did not either identify areas of strength, areas of need, and/or did not offer specific recommendations (Individual #271, Individual #156, Individual #139, and Individual #184). In addition, it was not always apparent that the PFA was completed prior to the ISP as expected (i.e., Individual #190). Overall, out of the 14 individuals sampled, it appeared that only two (14%) of the individuals' PFAs were current, complete, and available prior to the ISP. Of the 14 individuals in the sample, documentation evidenced completion of FSAs for only 13 (93%) individuals. That is, the FSA for Individual #31 was not available. Of the 13 available FSAs, 12 (92%) appeared to have been completed within the last 12 months.	Noncompliance

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		More specifically, the FSA for Individual #35 was completed over 12 months from the date of the Monitoring Team's current visit. Of all the available FSAs (including those that were outdated), only three (23%) appeared to be adequately completed. These included the FSAs for Individual #57, Individual #237, and Individual #115. More specifically, the FSAs for ten individuals either did not adequately summarize the assessment and/or offer specific recommendations (i.e., Individual #240, Individual #124, Individual #190, Individual #271, Individual #306, Individual #35, Individual #156, Individual #6, Individual #139, and Individual #184). Overall, it appeared two of the FSAs (14%) were current, complete, and available prior to the ISP. The above findings continued to evidence that the PFAs and FSAs were not adequately completed. That is, they were not completed as designed, and, as a result, did not provide specific recommendations. The Facility should ensure that all staff assigned to complete these assessments are trained and monitored so that the assessments are completed adequately and that they accurately inform the ISP. Documentation provided suggested that steps to ensure the timeliness of the PFA had been initiated. That is, it appeared that a monitoring tool had been created to track the completion of PFAs. However, this did not appear to have been completed for FSAs. In addition, there currently was no system in place to ensure the quality of these assessments. However, documentation revealed that efforts were underway to determine a checklist to examine the quality of SAPs. Perhaps a similar tool could be created to examine the quality of PFAs and FSAs. Documentation provided indicated that efforts to revise current State Office policy with regard to practices related to the completion of vocational assessments had been initiated. The new policy described procedures, form instructions (consistent with the revised format), and schedules for administration. Documentation demonstrated that in January 2012, vocational service staff were trained on the new policy. The policy stated that comprehensive assessment would be completed every three years for all individuals, unless the IDT provided sufficient justification. In addition, annual updates would be completed for individuals actively involved with the vocational department or for individuals the IDT referred. Unfortunately, this appeared to suggest that some individuals not currently integrated in vocational settings could go years between assessments. This could be detrimental to individuals who actively refuse vocational placements. In other words, if an individual refused vocational supports, he/she would fall into the category of not receiving them currently, and only requiring vocational evaluation every three years. This would result in potentially missed opportunities to identify an appropriate vocational activity for the individual. For this review, vocational assessments were examined for the 14 individuals included in the sample. Documentation provided indicated that since the Monitoring Team's last	

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		visit, 40 vocational assessments had been completed. According to completion dates of the selected assessments, the current sample represented approximately seven (18%) of those completed since the Monitoring Team's last visit. Of the 14 individuals, completed vocational assessments or vocational updates were available for 12 (86%) individuals. That is, vocational assessments were not provided for Individual #156 and Individual #6. Of these, only eight (67%) had been completed within the last 12 months. More specifically, the vocational assessments provided for four individuals were completed over 12 months from the date of the Monitoring Team's current visit. This included, Individual #115 (dated 2/1/10), Individual #139 (dated 9/17/09), Individual #184 (dated 11/9/09), and Individual #306 (dated 1/23/08). In addition to not being updated on an annual basis, the vocational update for Individual #139 and Individual #184 were extremely inadequate and incomplete. An update as well as the previous vocational assessment template was completed for Individual #306. Both of these documents appeared inadequate. The same outdated template was also completed for Individual #115. The most current vocational assessment template was utilized for eight (57%) of the 14 individuals sampled. However, the vocational assessment for Individual #57 was only partially completed. More specifically, according to information on the assessment, the individual did not attend any of the scheduled appointments, and, as a result, the assessment could not be completed. Consequently, it appeared that only seven (50%) of the 14 individuals sampled had a recent vocational assessment completed. Of these, zero (0%) appeared to be adequately completed. That is, one or more of the expected content areas of the assessments appeared inadequate across all of the individuals reviewed. One assessment (for Individual #240), however, appeared to be of higher quality than the other assessments reviewed. Unfortunately, the one area where this assessment appeared limited was the one component central to revised template, specifically, the vocational exploration situational assessments. More specifically, there appeared to be inconsistency between the voiced preference and stated vision detailed within the assessment and the opportunities provided as part of the vocational exploration. In addition, it was unclear whether or not any actual situational assessments were formally completed either in his current placement (warehouse) or in other more preferred settings. Overall, the review only found evidence that actual situational assessments were documented for two (29%) of the seven individuals with assessments following the revised template. This included Individual #35 and Individual #271. This finding might actually be inflated, because the "situational assessments" completed for Individual #35 did not actually include any new settings or activities typically associated with vocational exploration. That is, the listed activity appeared to involve only his current job in his current job setting. Although it appeared that this might have occurred due to the	

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		individual's reluctance to try other jobs (which is acceptable), listing this experience as repeated situational assessments did not reflect the true intent of conducting vocational exploration. The remaining situational assessments involved a similar finding where the individual was assessed in three activities/environments, two of which appeared to match current work placements (Individual #271). In addition to the limited vocational exploration experiences, other concerns were noted within the reviewed assessments. In most assessments, a vocational/employment vision was not described. However, there were exceptions where a vision or at least a preference was described (e.g., Individual #237, Individual #240, and Individual #31). Also, across most assessments, it was not evident that specific findings were well-integrated into the summary sections of the report. For example, all but two assessments provided no or very limited information when describing the strengths of the individual (the exceptions were Individual #237 and Individual #240). This was an interesting finding given that the assessment identified many characteristics, many of which could be viewed as strengths, which could have been thoughtfully integrated into summary sections. Indeed, the needs and barriers section appeared sufficiently described across many individuals. Lastly, the information provided regarding ideas for the future as well as recommendations appeared vague, too general, and often limited to opportunities only found on campus. These findings were consistent with findings noted in the Monitoring Team's previous reports, and given the similar limitations and inadequacies as described above, the Facility remained out of compliance with this provision.	
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	As previously discussed (with regard to Section S.1 of the Settlement Agreement), evidence indicated that needs related to SAPs were identified in 78% of sampled individuals' ISPs. Approximately 67% of those sampled identified a specific assessment within the rationale section of the plan that was the basis for targeting the current skill. In addition, findings previously noted suggested that it was unlikely that the majority of SAPs, including desensitization programs, were currently promoting growth, development, and independence across most individuals served at LBSSLC.	Noncompliance

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	consistent with the individual's needs, and	Efforts to ensure integrity of implementation of SAPs included identifying select members of the Residential Services Department and providing more robust training. More specifically, documentation indicated that, in addition to Active Treatment staff, other selected clinical, administrative, and direct support professionals, including psychologists, residence coordinators, home time leaders, and assistant home team leaders, were identified in each residence and subsequently trained during February 2012. Training documentation indicated that between two and five additional staff were trained to be SAP trainers at most residential sites. Staff at Violet (523) were not trained. However, evidence provided did not demonstrate that these staff members were determined to be competent trainers using any structured competency-based assessment methodology. Other efforts to ensure the adequate training and procedural integrity of SAP implementation included monthly meetings with Active Treatment staff, Unit Directors, and the Director of Residential Services. Documentation indicated that two meetings were held in January and February 2012, and focused on program engagement observations, inter-rater reliability of program monitoring, and responses to performance measures that were assessed to be inadequate. It appeared that efforts were being made to improve the nature of skill programming and active treatment in the residential programs. Similar efforts directed at vocational and day programs have not yet been observed. Overall, the Facility will need to demonstrate integration of the new SAPs, with adequate integrity, across vocational and day programs.	
	(b) Include to the degree practicable training opportunities in community settings.	Findings from the Monitoring Team's previous reviews indicated that the majority of individuals did not have SAPs designed for implementation within a community setting. That is, past findings from sampled SAPs indicated that approximately 50% or less of those sampled had at least one skill plan identifying the community as the setting (or potential setting) for training. Currently, of the nine individuals sampled (in Section S.1 a description is provided of the sample), three (33%) had SAPs that were specifically identified for completion either on or off-campus (i.e., Individual #237, Individual #192, and Individual #31). This suggested that of approximately the 30 SAPs developed for these nine individuals, three (10%) prescribed their completion either on- or off-campus. This finding was consistent with previous findings, and did not support improvement in providing training opportunities in community settings. As observed during the Monitoring Team's previous visits, summary data of community outings reflected a surprising variability in the number of community outings offered per month over time. Currently, data from September 2011 reflected an overall decreasing trend from September 2011 through February 2012. Similar to the Monitoring Team's previous visits, a substantial amount of data was provided regarding trips that individuals participated in that facilitated skill acquisition programming. However, there	Noncompliance

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		was no summary data available to explain the voluminous data that was collected. Consequently, there did not appear to be an efficient way to identify the number of individuals who had skill acquisition programs intended for completion in the community, or a system to monitor their ongoing performance on these programs while in the community. This finding was consistent with findings noted in the Monitoring Team's previous reports. The Facility is strongly encouraged, once again, to consider examining 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.	

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 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 accurately reflect the revised formats currently in place. (Section S.1)
3. The Facility should ensure that SAPs (including desensitization plans) 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;
    i. Identification of chaining methodology (forward, backward, or total task); and
    j. Specific rationale that describes the basis for why the SAP is in place (identify the assessment and identified need). (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 the data collected, 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, QDDPs and Residential Coordinators, and other IDT team members receive the training necessary to adequately develop, train, and monitor these skill programs according to the new policy and format. This includes assessing and documenting that they have the competencies to train staff on the implementation of SAPs. (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. SAPs should include a description of the rationale for its development, including identification of the assessment and need that were the basis for the SAP. (Section S.1).
11. The Facility should revise items on the Program Observation Drill to more closely reflect staff behavior when actually implementing SAPs. That is, revisions should mirror those recent changes observed in integrity checks on the new streamlined PBSPs. (Section S.1).
12. The Facility should ensure adequate and timely completion of the PFA and FSA prior to the ISP. (Section S.2)
13. The Facility should continue to implement the new Vocational Assessment, including an emphasis on integrating current findings as well as improving the application and integrity of direct evaluation through vocational exploration (situational assessments) targeting new employment positions especially in community-based settings. (Section S.2)
14. If not already in place, the Facility should determine an effective method of aggregating and summarizing the data Active Treatment staff collect (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 to significantly increase the integration and completion of SAPs in day program, vocational settings, or community-based settings. Instead of the majority of current skill acquisition programs being completed in residential programs, 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 LBSSLC Self-Assessment, updated 2/29/12; o List of individuals referred for placement, undated; o List of individuals who have requested community placement, but have not been referred, undated; o List of individuals not referred due to Legally Authorized Representative (LAR) preference, reporting dates 10/1/11 to 2/10/12; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed, undated; o Community Placements since 10/7/11; o LBSSLC ISP Dates and Placement Results, undated; o Since the last review, a list of training educational activities opportunities provided to individuals and/or Legally Authorized Representatives (LARs) to enable them to make informed decisions regarding community options, including list of participants, undated; o Annual Report: Obstacles to Transition Lubbock State Supported Living Center, Fiscal Year 2011; o Since the last review, a list of individuals who have returned from a community placement: "There have been no returns from a community residential placement 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: "There have been no deaths of individuals transitioned from this Facility to the community since 7/01/09;" o Since the last onsite review, a list of individuals discharged pursuant to an alternate discharge: "There have been no alternate discharges since the last review," undated; o Since the last review, a list of all individuals who have transferred to other SSLCs, including name, and date of transfer: "There have been no transfers to other SSLCs since the last review," undated; o In response to a request for the last one year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason;

	and/or 8) been restrained, including a brief description of any action the Facility took with regard to any of these occurrences: "Per DADS State Office, this information is not being considered for tracking. Through the post-move monitoring process, any of the events listed would be captured and documented;" o A current list of alleged offenders committed to the Facility following court-ordered evaluations, undated; o Community Placement Report, from 10/1/11 through 2/10/12; o LBSSLC Obstacles Report: Reporting Dates 10/1/11 through 2/10/12; o Description of how the Facility assesses individuals for placement, 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: Admissions Process, revised 2/14/12; o LBSSLC – Continuity of Services: Community Placement, revised 2/14/12; o LBSSLC – Continuity of Services: Discharges, revised 2/14/12; o LBSSLC – Continuity of Services: Final Summary, revised 2/14/12; o LBSSLC – Continuity of Services: Transfer Between State Supported Living Centers, revised 2/14/12; o Most recent tracking guides/log for staff participation in: a) community home visits; and b) Provider Fairs; o Community Living Discharge Plan, related assessments, sign-in sheet, and most recent ISP for: Individual #48, Individual #173, and Individual #166; 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 #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, and Individual #199; o Pre-Move and Post-Move Monitoring Checklists for: Individual #134, Individual #48, Individual # 166, and Individual #173; o State Office reviews of CLDPs for Individual #48 and Individual #173; o QA Monthly Summary Data for Section T, from September 2011 through February 2012; o Last 10 monitoring tools completed by: 1) the QA Department; and 2) the Admissions Placement Department, various dates; o QA Monthly Meeting minutes from 10/11 through 2/12; o State Office reviews of Living Option Discussions, for last six months; o Special Review Team documentation for Individual #211 and Individual #240; and o Presentation Book for Section T. ▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; o Annette Webster, Post-Move Monitor and Guardianship Coordinator; o Debbie Burgett, State Office Continuity Services staff member; o Lola Walker, QDDP Coordinator;

	○ Marisol Gonazales, ISP Coordinator; and ○ Sandra Kennedy, QDDP Educator. ▪ **Observations of**: ○ ISP meetings for the following: Individual #51, Individual #98, and Individual #259.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section T of the Settlement Agreement, the Facility found that it was in compliance with the following subsections: T.1.c.2, which requires specifying staff responsible and timeframes for completion of action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.h, which requires the Facility to provide a Community Placement Report; T.2, related to post-move monitoring; and T.4, related to alternate discharges. Not all of these findings were consistent with the Monitoring Team's findings. Specifically, the Monitoring Team did not find the Facility in compliance with T.2 for the reasons discussed in the report. It was unclear why the Facility found itself in compliance with Section T.4, because no records were available for review. No alternate discharges had occurred. Since the Monitoring Team's previous review, the Facility begun to make improvements in the justification it offered for its findings. Over as short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self-assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted: ▪ The Facility's Self-Assessment did not consistently define how the samples were selected, or give a sense of whether they were representative samples. Sometimes the latter was provided, for example, when talking about the CLDPs reviewed. ▪ It was not clear what standards were being used, and/or if the quality of the supports and services were being assessed. For example, with regard to Section T.1.b.1, it was not clear if the quality of the Living Options Discussions and/or the protections, supports, and services was reviewed, or just the mere presence of these items. Similarly, for Section T.2, it did not appear that the quality of post-move monitoring was reviewed, just the timeliness of the monitoring. ▪ In addition, not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment. For example, with Section T.2, no review appeared to occur with regard to the Facility's "best efforts" to ensure that missing supports or services were provided to individuals who had transitioned to the community. If the Facility was choosing, for example, to prioritize assessing certain areas before others, that would be acceptable, but it should be stated specifically. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., Post-Move Monitor and QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed to add or revise the guidelines/instructions for the audit tools. This will be essential to improve the accuracy of the

	monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ Frequently, the data showed 100% compliance, but the Facility acknowledged it remained out of compliance. This appeared to indicate that the measurements the Facility was using were not yet adequate to assist it in defining where it was doing well, and where improvements were needed. It was positive that the QA and Admissions Placement Departments had begun to meet regularly to discuss monitoring efforts and results. Ongoing efforts to ensure the validity and reliability of the data will be important, as will identifying appropriate measures and criteria, and further using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section T is discussed in further detail below with regard to Section T.1.f.
	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. More teams were using the standardized list. However some teams still identified individuals' needs as the obstacle to placement as opposed to the lack of supports in the community to meet the individuals' needs. Based on the Monitoring Team's review of action plans to overcome the obstacles identified, few included plans, and problems were noted with their quality and individualization. The teams at LBSSLC had begun to implement 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 Not all assessments included this piece. However, team discussions, as documented in a sample of recent ISPs, often reflected disagreements amongst professional members of the team that were not resolved. Even when team members agreed, the discussion reflected a polling of team members as opposed to a consensus. As a result, the professional members of the team did not make one joint recommendation to the individual or the Legally Authorized Representative. With regard to the identification of essential and nonessential supports, since the Monitoring Team's last review, no progress had occurred. Since the last review, only three individuals had transitioned from the Facility to the community. Better documentation was available 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. However, follow-up of concerns that were identified was not consistently completed.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental 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, no one listed as having been referred to the community had been on the list for 180 days or more. Since the last review, in assessments prepared for annual ISP meetings, improvement was seen in the inclusion of the assessor's recommendation regarding transition to the community. Some assessments still did not include such recommendations (e.g., psychiatry, vocational assessments, and FSAs). Based on review of a sample of ISPs, although teams documented in the ISPs their discussion about each team member's recommendation, ISPs generally did not include a summary or conclusion with regard to the professional team members' joint determination or recommendation with regard to	Noncompliance

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		whether or not community placement was appropriate. Based on a review of nine ISPs (including those for Individual #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, and Individual #199), the following was found: ▪ Of the nine ISPs reviewed, one individual (i.e., Individual #107) had been referred for transition to the community a few months previously, so this was not reviewed again. ▪ For the remaining eight individuals, team disagreements were noted in either the ISP document or the assessments for six individuals (75%) (i.e., Individual #237, Individual #160 per the assessments, Individual #318, Individual #23, Individual #29, and Individual #199 per assessments). Of these, one individual (i.e., Individual #237) was referred, and it was not clear how the team disagreement about this had been resolved. It was not clear for any of these individuals that the professionals on the team offered one joint recommendation to the individual and guardian. ▪ For two individuals (25%) (i.e., Individual #84, and Individual #184), the teams were polled and all team members agreed the individuals could be served in a less restrictive settings. However, it was unclear that this was made as a joint recommendation of the team to the individual and guardian. Rather, the teams indicated that the LAR objected, and, the team agreed the individual should not be referred for transition. As was discussed at the parties' meeting in June 2011, 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 three individuals had transitioned to the community. LBSSLC recognized the need to increase referrals to the community. As noted in the Monitoring Team's last report, 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 QDDPs, the Local Authority staff, Unit Meetings, and community providers; and continuing efforts such as the provider fairs. One example of this was on October 28, 2011, Continuity of Services Living Options Training was mandatory for all IDT members. It included information about the Community Living Options Information Process (CLOIP), the referral process, as well as information about various options in the community. However, based on the sign0in sheets provided, the compliance rate for	

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		staff's attendance could not be determined, because the overall number of staff as compared with the number who attended was not provided. At the time of the review, eight 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, in February 2012, the Facility had updated policies in the Continuity of Services section. These are listed in the documents reviewed section. Reportedly, changes were made to align the policies with the most recent State Office policy. However, based on documentation in the Section T Presentation Book: "The updated draft version of the Most Integrated Settings Policy was received on 03/06/12. Comments are due to State Office on 03/23/12. A thorough discussion of this policy will be conducted during the Admissions Placement Coordinator/Post Move Monitor training from 04/11/2012 to 04/13/2012. Once the updated version of the Most Integrated Settings Policy is adopted, the local Most Integrated Settings procedure will be updated." In addition to providing copies of the revised policies, the Presentation Book included copies of sig-in sheets for staff training on the policies. However, the raw data could not be interpreted. No information was provided regarding the number of staff who were required to complete the training (N), and the number of these staff that had completed it (n). 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 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	As noted above with regard to Section F of the Settlement Agreement, LBSSLC had continued to make efforts to improve ISPs. The revised ISP format included subsections related to the individual's living options. These sections included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, and obstacles that the IDT identified. A section also was included for the team/disciplines' recommendation. A review was conducted of a sample of nine ISPs. The findings related to this review are discussed below with regard to the two requirements 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	Noncompliance

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	annually, and shall identify, and implement, strategies intended to overcome such obstacles.	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, services and supports were not being adequately integrated with one another, and/or adequate plans were not being developed to address individuals' preferences, strengths, and needs. 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 nine 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 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 ISPs. 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	

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		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, as the Monitoring Team indicated in the last report, LBSSLC had had some delays in implementing the State Office list, but retraining had occurred and teams had been instructed to begin using the standardized list on 9/1/11. In reviewing the sample of nine ISPs, teams had discussed some obstacles. Of the nine ISPs reviewed, seven should have had obstacles defined, because two of the individuals had been referred to the community. Of the seven plans, four (57%) conformed to the State Office's standardized list. For all of these individuals, guardian and/or individual reluctance was listed. The problems associated with the obstacles in the plans included the following: ▪ 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 #199, "need for 24/7 nursing services due to his G-tube," Individual #27's need for specialized medical supports, Individual #23's serious behaviors due to pica); and ▪ When guardians or individuals objected, adequate inquiry generally did not occur with regard to specifically what their concerns were. The only individual for whom this occurred adequately was Individual #318. This is very important information to collect and analyze, but it did not appear it was being captured regularly. Based on the Monitoring Team's review of action plans to overcome the obstacles identified, of the seven ISPs in which such plans should have been included, two (29%) (i.e., Individual #23 and Individual #318) included an action plan to overcome obstacles identified. However, only one (14%) was adequate. More specifically, the plan for Individual #23 was individualized, and included activities to try to identify supports that would meet the individual's behavioral needs, as well as his needs for an accessible home. In contrast, the plan for Individual #318 was generic and not individualized. 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 initial 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.	

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	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Similarly to the previous reviews, 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. These activities included: ▪ The Admissions Placement Coordinator submitted an article, and in December 2011, it was published in "New… News by Dominick." The article addressed community exposure tours. ▪ The Admissions Placement Coordinator had continued to be involved with the Self-Advocacy Group. During the meeting that occurred the week of the Monitoring Team's onsite review, staff members from the Local Authority gave a presentation. The Admissions Placement Coordinator had been working closely with the Local Authority, and it was anticipated that they would have more presence on campus, including planning some fun activities that also would provide an educational component about community options. This partnership was very positive. ▪ As noted in the Monitoring Team's last report, the Facility had increased its community exposure tours from once to twice a month. They continued to occur on the second and fourth Tuesdays of the month. ▪ 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. One was held on September 18, 2011 in conjunction with the Family Association meeting. Another recently had been held on March 7, 2012. Invitations were sent to 25 providers, 17 responded, and nine set up booths. Invitations were sent to all 260 correspondents, but only one attended. All individuals were invited, and 97 attended the fair. All 850 staff were invited, and 136 attended. During this provider fair, a new feature was a panel discussion. It was well received, and based on staff's descriptions, many good questions were asked and answered regarding options and supports available in the community. As in the past, interview questions also were made available to individuals and staff to help structure the questions they asked providers. ▪ On October 28, 2011, the Local Authority provided 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 Living Options sections of the	Noncompliance

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		nine ISPs were reviewed. Two of these individuals had been referred for transition. For the remaining seven, two included no action plan (i.e., Individual #160, and Individual #184), four had plans that were inadequate (i.e., Individual #199, Individual #29, Individual #84, and Individual #318). The only plan that was adequate was the one for Individual #23. 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. ▪ Action plans that were developed were generic in nature (e.g., attend provider fairs, and participate in community tours), and did not reflect the individualized needs. 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 Facility staff indicated they likely would do this annually. 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 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	The Monitoring Team requested for the last 12 months, a list of individuals who had been assessed for placement. In response to this request, LBSSLC submitted a list of individuals with their most recent ISP date, and an indication of whether or not the IDT had made a referral. As discussed with regard to Section T.1.a, since the last review, in assessments prepared for annual ISP meetings, improvement was seen in the inclusion of the assessor's recommendation regarding transition to the community. Some assessments still did not include such recommendations (e.g., psychiatry, vocational assessments, and FSAs). In addition, based on review of a sample of ISPs, although teams documented in the ISPs	Noncompliance

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	of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	their discussion about each team member's recommendation, ISPs generally did not include a summary or conclusion with regard to the professional team members' joint determination or recommendation with regard to whether or not community placement was appropriate. Based on a review of nine ISPs (including those for Individual #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, and Individual #199), the following was found: ▪ Of the nine ISPs reviewed, one individual (i.e., Individual #107) had been referred for transition to the community a few months previously, so this was not reviewed again. ▪ For the remaining eight individuals, team disagreements were noted in either the ISP document or the assessments for six individuals (75%) (i.e., Individual #237, Individual #160 per the assessments, Individual #318, Individual #23, Individual #29, and Individual #199 per assessments). Of these, one individual (i.e., Individual #237) was referred, and it was not clear how the team disagreement about this had been resolved. It was not clear for any of these individuals that the professionals on the team offered one joint recommendation to the individual and guardian. ▪ For two individuals (25%) (i.e., Individual #84, and Individual #184), the teams were polled and all team members agreed the individuals could be served in a less restrictive settings. However, it was unclear that this was made as a joint recommendation of the team to the individual and guardian. Rather, the teams indicated that the LAR objected, and, the team agreed the individual should not be referred for transition. As was discussed at the parties' meeting in June 2011, 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. It is important to note that for some individuals, teams seemed to have limited or differing knowledge about community options available. These teams, or at least some members of these teams, seemed to believe the individuals would do well in community settings "if appropriate supports were available" or if they could be funded appropriately (e.g., Individual #23's team that expressed concerns that he would need a "behavioral bump"). These would be individuals for whom teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be	

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		able to support the individual. The team could support the individual and his/her guardian to explore these different options to determine if they meet the needs as well as the preferences of the individual. To ensure that this process occurred expeditiously, an action plan should be developed with specific action steps and associated timeframes, and persons responsible.	
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:	Since the last review, essentially no progress had been made with regard to the CLDPs. They continued to need significant improvement. Since the last review, only three individuals had transitioned to the community. All three of these individuals' CLDPs were reviewed (i.e., Individual #48, Individual #173, and Individual #166). This represented 100% of the relevant CLDPs. With regard to the timeliness of the Community Living Discharge Plans, the three plans were developed between a month and to less than a week prior to the individual's transition. However, it was clear from the narrative that the teams had met a number of times between the time of the individuals' referrals and the time of the transition. 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 ISPAs, 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. With regard to the timeliness of the development of CLDPs, the Facility had made progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate CLDPs.	Noncompliance
	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 Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, none of the three 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 plans identified the need for training for community provider staff. However, they 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 plans 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	Noncompliance

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		competency in actually implementing a plan, such as a PBSP, nursing care plans, etc. For some individuals, specific components of their ISPs 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 required that the community provider staff have the competencies necessary to safely support the individual. ▪ Missing from the plans 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 individuals (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 described 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. ▪ The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of essential and non-essential supports. 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.	

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	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, teams identified target dates for the completion of actions steps included in CLDPs, as well as the person responsible by name. This was evident in three out of three 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-making regarding the supports and services to be provided at the new setting.	From the sign-in sheets provided with the CLDPs that were reviewed, it appeared that the teams reviewed the CLDP with the individual or guardian prior to the individual's transition. For three of the three 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 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.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	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 of the three individuals' CLDPs reviewed (33%), it appeared that assessments had been updated within the 45-day timeframe. For the remaining two, some assessments were not dated, and, as a result, it could not be determined whether or not they were updated within 45 days. The quality of these assessments was lacking. None of the three 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 been particularly	Noncompliance

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		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, 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.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. In various other sections of this report, the Monitoring Team included transition assessments in their sample of assessments reviewed. Consistently, the Monitoring Team found them to be inadequate to provide the IDTs with adequate information with which to develop an appropriate CLDP or to offer community providers with the information necessary to ensure a safe and successful transition for the individual. Commentary with regard to the adequacy of assessments for these purposes can be found with regard to Sections L, and M of the Settlement Agreement. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessment is necessary.	

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T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDP reviewed included essential and non-essential supports. Since the Monitoring Team's last review, this was an area in which no progress had been made. 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 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 three plans 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 without any supports at all, and then identifying 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 CLDPs, the intensity of the supports was not identified, nor were the qualifications or the roles of clinicians clearly defined. Supports defined as "psychological consultation to monitor for the need for a behavior plan," 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	Noncompliance

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		could be provided in the community. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans that the Facility had begun to develop, albeit still inadequate, were not reflected in action plans included in the CLDPs reviewed. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. ▪ In addition, clinical supports that LBSSLC was providing, based on assessment information, were not included in the CLDPs, 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 CLDPs. ▪ 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 CLDPs required that community staff be trained on existing plans. However, as noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training. ▪ The CLDPs did not identify as an essential or nonessential support that treatment plans be implemented (e.g., PBSP, nursing care plans, health management plans, diets, exercise programs, etc.). ▪ Although it appeared that the individuals reviewed had specific health care indicators that needed to be monitored and reported (e.g., input/output, meal refusals, psychiatric symptoms, etc.), very few of these were identified (e.g., seizures, and bowel management plan for one individual). 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. For example, for Individual #48, prolonged seizures were identified as requiring intervention, but no information was included about the parameters for notifying a nurse, or the expectation of the "intervention." ▪ 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. As illustrated by a crisis situation that Individual #173 experienced after his transition, 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	

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		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. ▪ 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 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 <u>could be</u> 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	

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		Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of three individuals' pre-move site visit documentation (i.e., Individual #48, Individual #173, and Individual #166. They appeared thorough, and included each essential support listed in the individuals' CLDPs. They identified the evidence that had been reviewed to determine that the essential support was in place. They appeared to have been completed in a timely manner. 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.	Since the last review, some changes had occurred to the monitoring process. The Program Compliance Monitor continued to conduct monitoring of Living Options Discussions and CLDPs. In December 2011, her monitoring of post-move monitoring was discontinued. This reportedly was being assigned to someone in State Office. The Admissions Placement Coordinator had continued conducting monitoring of Living Options. However, in October and November 2011, some monitoring did not occur due to understandable circumstances. For the Living Options Discussion, similar to changes in the sampling of the ISPs, four were chosen each month for which the meetings had been held 60 days prior to ensure that the documents were available for review. The Program Compliance Monitor and the Admissions Placement Coordinator reviewed all four. The Program Compliance Monitor and Admissions Placement Coordinator continued to meet monthly. Based on verbal report as well as review of the minutes from these meetings, the only issue identified was the lack of timely filing of ISP documents in the records. Given the significant problematic issues, this limited finding, as well as the problems noted with regard to the Facility's Self-Assessment were concerning in light of the ongoing and unresolved issues the Monitoring Team found with regard to Section T. On a positive noted, in March 2012, it appeared that the Program Compliance Monitor, QDDP Coordinator, and Admissions Placement Coordinator had scheduled a meeting to develop additional monitoring systems. However, at the time of the review, results from this collaboration were not yet available. Of significant concern was the Facility's response to the Monitoring Team's request for the last one year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: 1) had police contact, and if so	Noncompliance

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		the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason; and/or 8) been restrained, including a brief description of any action the Facility took with regard to any of these occurrences. The Facility's response read: "Per DADS State Office, this information is not being considered for tracking. Through the post-move monitoring process, any of the events listed would be captured and documented." In order for an adequate quality assurance system to be in place with regard to Section T, outcome measures need to be available to measure individuals' successes as well as problems in the community. This is necessary to assist the Facility to determine if its planning and implementation of individuals' transition are adequate. Other concerns with regard to the quality assurance processes included: ▪ Inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. 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. In summary, 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 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, the Facility's lack of tracking of essential outcome measures related to the transition of individuals to the community should be reconsidered. Finally, as corrective action plans are developed, it	

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		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.	Activities at the Facility and State levels demonstrated progress towards substantial compliance with this provision item. The State issued the Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2011, with data current as of 8/31/11. The Facility was beginning to gather data on the obstacles. However, this remained limited: ▪ Data for five fiscal years, 2007 through 2011, were reported in the new annual report. Data included number individuals who moved to the community, deaths, and discharges to other placements. Data also was provided for these timeframes on numbers of individuals referred for community placements, the number of rescinded referrals, community transitions, and numbers of individuals who returned from community transitions. ▪ Limited data were included in the report regarding the types of obstacles identified, and the concerns of LARs and individuals that led to their preference to not be referred. At the time, approximately 225 individuals resided at LBSSLC. However, data was provided on obstacles for only 87 individuals (39%). ▪ The data system only allowed one obstacle to be recorded per individual. This confounded the data. ▪ The data on the 87 individuals indicated that 48 (55%) were not referred due to LAR reluctance. The data system, however, did not indicate if this was the sole reason for non-referral, or if it was one of a number of obstacles. The report included some breakdown of this data, and identified the need to take some actions to address potential misunderstandings about supports available in the community. The Facility also recognized the need to develop individualized action plans to address some LARs' concerns. The LBSSLC report did not yet include an analysis of the overall data included in the report: ▪ As noted, data accuracy and validity needed to be improved. ▪ Assistance from the QA Department and State Office might be helpful in analyzing data once it is collected. For example, graphs of the data could be trended over successive months, and analysis could be completed. ▪ Facility staff's knowledge of the underlying issues could be helpful in identifying potential solutions to existing obstacles. DADS took steps to overcome or reduce the obstacles that had been identified, including: ▪ DADS created a report summarizing obstacles across the state, and included the	Noncompliance

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		Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. ▪ The statewide report listed the 13 obstacle areas used in FY11. DADS was planning improvements to the way it categorized and collected (and the way it had the Facilities collect) data regarding obstacles. ▪ DADS indicated actions that it would take to overcome or reduce these obstacles: o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description regarding whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community	In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report, for the period between 10/1/11 and 2/10/12. The report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Eight individuals were included on this list. ▪ 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 three individuals. 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:	Substantial Compliance

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	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.	▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the names of two 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 two individuals, including the date of the meeting and a brief description of the reason for the referral not being made. For one individual, the reason was noted as "Behavior/Psychiatric," and for other individual, the reason stated: "MRA Not Present." For the individual for whom the MRA was not present, it was not clear why this had not been resolved, given that the original meeting was held in October 2011. ▪ LAR Prefers Community, Not Referred: No individuals were listed in this category. 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. In the Monitor's recent conversation with the Department of Justice, confirmation was obtained that the State was providing them with these reports.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for three individuals (i.e., Individual #48, Individual #166, and Individual #173). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted nine reviews. Of the nine required visits, nine (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	Noncompliance

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	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.	day sites of the individuals, and that this was clearly documented in the reports. Except for times that the individual was discovered not to be at the day program, the Post Move Monitor had visited the individual at his/her home, as well as day/vocational site. <u>Content of Checklists</u> LBSSLC continued 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. Each of the items on the checklists reviewed had been addressed. Additional information had been added regarding the interviews conducted, the documents reviewed, and the observations made. The checklists reviewed were completed thoroughly. A concern was noted with regard to the content of the 90-day checklist for Individual #166. In the evidence column, notes indicated that the individual was spitting out his medications. The support was listed as: "Ensure he swallows his medication and does not induce vomiting or throw it in the trash." This was marked "yes" as having been completed. Although the narrative of the report indicated that some level of follow-up was done, no follow-up was documented as having been completed with the provider. This is discussed in further detail below. <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 #166. ▪ Of the one individual for whom follow-up was indicated, documentation was present to show that for none (0%), adequate follow up had occurred. More specifically, the 90-day monitoring form indicated that the non-essential support of scheduling a psychiatric appointment within the first 90 days had not occurred. The only notation was that an appointment had been scheduled for over four months after the due date. No documentation was provided to show that the Facility had exerted its "best efforts" to ensure these supports were provided. Based on interview with staff, the provider had had difficulty finding a psychiatrist who would accept the individual. However, it was unclear what efforts the Facility had been made, and/or if the IDT at LBSSLC had been asked to become involved or to provide an opinion about the potential impact of such a delay. Similarly, as noted above, no follow-up appeared to have occurred to ensure that the community provider was following through on the support identified in the CLDP with regard to ensuring the individual swallowed his	

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		medications. It should be noted that the Facility did follow-up to assist the community provider and the individual in maintaining his job despite behavioral issues. Although in the Monitoring Team's last report, the Facility was found in substantial compliance with this provision, as was indicated in the last report, 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. As noted above, adequate follow-up had not been completed for one of the individuals in a small number of individuals who had transitioned to the community. This follow-up is essential to ensuring individuals' success in the community. As a result, the Facility has been found to be in noncompliance with this provision.	
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, no post-move monitoring visits were scheduled. As a result, the Facility's compliance with 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) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do		

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	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. However, since the previous review, based on documentation the Facility provided, no individuals had had an alternate discharge, and no individuals had transferred to other SSLCs. As a result, the Facility's compliance with this provision was not rated.	Not Rated

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 and/or technical assistance 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. For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible;

g. 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;

h. 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;

i. 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;

j. 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;

k. 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.);

l. 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;

m. 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;

n. 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;

o. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle; and

p. 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;
    e. Develop a set of outcome indicators to measure both positive and negative outcomes for individuals who transition to the community; and
    f. Analyze information resulting from monitoring activities and outcome measures, 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 and Facility Self-Assessment)
14. Whenever appropriate, IDTs should identify actions necessary to resolve issues related to the essential and nonessential supports provided to

individuals who have transitioned to the community. The IDTs decisions and activities should be documented through to completion. (Section T.2.a)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: o **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 In response to request for any new or updated policies, the statement: "There have not been any changes or modifications to the Guardianship policy since last visit;" o Prioritized List of Those in Need of and Legally Authorized Representative (LAR), revised 3/13/12; o New Guardians Since 10/1/11, undated; o In response to document request, statement that: "Currently, at this time, there are no new instruments or process to determine an individual's functional capacity or used to prioritize the needs of an individual at this time;" o In response to curriculum for above-noted processes, the statement: "…no curriculum for training on instruments or processes…;" o Contact Log regarding guardianship from 9/6/11 through 2/9/12; o Presentation Book for Section U; o Self-Assessment for Section U, updated 2/29/12; o Section U Presentation LBSSLC Monitors' 4th Compliance Visit March 2012; o Provision Action Information, undated; o Action Plans: Section U, undated; o Individual Support Plans (ISPs), related assessments, Personal Focus Assessment (PFA), ISP signature sheet, Individual Support Plan Addenda (ISPAs), skill acquisition plans (SAPs), last three monthly reviews, last two quarterly reviews, daily schedule, and special considerations list for: Individual #237, Individual #84, Individual #160, Individual #318, Individual #107, Individual #23, Individual #29, Individual #184, and Individual #199; and o Blank monitoring form for Section U: Settlement Agreement Cross Referenced with ICF/MR Standards – Section U, dated, 12/10. o **Interviews with**: o Shelia Powell, Human Rights Officer/Guardianship Coordinator;

	o Annette Webster, Post-Move Monitor and former Guardianship Coordinator; and o Debbie Burnett, DADS State Office.
	Facility Self-Assessment: In its Self-Assessment, the Facility recognized that it was not in compliance with the requirements of Section U of the Settlement Agreement. This was based largely on review of existing policies, lists, and contact logs. LBSSLC had identified auditing of team meetings as one mechanism to ensure that teams discussed guardianship, as appropriate, and gave families and primary correspondents information about guardianship. However, data had not been collected yet. Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process will need to be modified. For example, 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. The Action Plan discussed below recognized this at least in part. In addition to providing statistics and narrative descriptions of activities, the self-assessment should include analyses of the audit results. The Facility also had developed an Action Plan related to Section U. The Action Plan involved a number of important and relevant issues. This included LBSSLC's staff participation in the finalization of State Office policy, and the development and implementation of a Facility policy once the State Office policy was finalized. In addition, efforts focused on identifying supports that might assist individuals in making decisions or participating in the decision-making process, training staff and IDTs, and auditing the IDT process once an assessment process was rolled out to determine functional decision-making capacity. With regard to Section U.2, the Action Plan indicated efforts would continue to be made to identify families and others interested in pursing guardianship, making external contacts to identify LARs for individual, and developing a guardianship assistance program with the Family Association. Although some of these action steps would have benefitted from further detail or sub-steps, the Action Plan generally set forth a reasonable approach to moving forward in efforts to comply with Section U. For example, the action step related to identifying resources and supports to assist individuals with decision-making did not include much detail or any sub-steps.
	Summary of Monitor's Assessment: DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this section of the Settlement Agreement. The Guardianship Policy had been disseminated, and the policy on consent remained in the development phase. The State Office Guardianship/Advocate policy just recently had been issued, and the Facility had not yet operationalized it. As discussed below, this resulted in limited progress being made at the Facility level. LBSSLC indicated that no instrument or process was available to determine functional capacity. It was anticipated that the State Office policy on consent would provide guidance with regard to this issue. In the meantime, the Human Rights Officer and Post-Move Monitor met with QDDPs to review the processes currently in place that could assist teams in beginning to better define individuals' decision-making capacity. These included the Rights Assessment, Functional Assessment, and Psychological Assessment

	processes. Since the last review, the Facility had modified the tool used to monitor ISP meetings. An indicator was added to determine if teams were discussing guardianship with families at individuals' annual ISP meetings. This was a positive addition. Based on the Monitoring Team's review of ISPs, although teams often identified that individuals did not have guardians and had difficulty with decision-making, the discussion appeared limited. In the ISPs reviewed, teams made no delineation of an individual's priority need for a surrogate decision-maker, and little planning appeared to occur in relation to alternatives to guardianship or identifying potential guardians. The updated prioritized list included names of 92 individuals served by LBSSLC. As described in the last report, teams had met, and with the assistance of the Human Rights Officer and Post-Move Monitor identified individuals' level of priority based on the list of factors delineated in the Settlement Agreement. At the time of the review, Lubbock supported 220 individuals, of whom approximately 42% 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, 42 individuals had a Priority I need for guardianship, 42 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. Since the Monitoring Team's last review, these efforts had been successful in securing guardians for eight individuals, with another two individuals in some phase of the process. These efforts consisted largely of identifying family members, friends, and former staff members to petition the court for guardianship. Since the last review, another success that the Facility had was in working with the Family Association to set up a fund to assist with guardianship costs for individuals for whom payment of the associated fees and expenses would potentially prohibit them from obtaining a guardian. Facility staff were in the process of developing an application form, and working with the Family Association to finalize the process that would be utilized to review and approve applications. The Family Association and the Facility should be commended for this joint effort that should assist greatly in obtaining guardians for individuals who need them.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision	At the time of the review, DADS State Office just recently had issued Policy #019: Guardianship, dated 3/7/12. Based on interview with Facility staff, they had not yet begun to operationalize the policy, and needed to review it in greater depth to determine what changes would need to occur at the Facility level. If the Monitoring Teams have any comments on the policy, the Monitors will submit them jointly. A second policy on consent reportedly was in development. Since the last review,	Noncompliance

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	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.	because LBSSLC was awaiting further guidance through State Office policy, limited progress had been made with regard to consent and guardianship. The State is encouraged to finalize the consent policy, because it should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. The Facility also is encouraged to review and implement the Guardianship Policy to the extent possible. However, the Monitoring Team recognizes that just as before this policy was issued, it will be difficult to fully implement this policy without further guidance from State Office with regard to screening for or assessment of an individual's "functional capacity to render a decision regarding the individual's health or welfare." Although the new policy set forth a process for prioritizing an individual's need for guardianship, this cannot be done adequately until a process is in place to screen for an individual's need for a guardian. 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. Now that the State Office had issued its Guardianship policy, Facility staff should review this policy to determine if need to be made. 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, although this process was still not being completed using an adequate standardized process, the Facility had taken some steps to involve teams more in discussion about individuals' needs for assistance in the decision-making process, including potentially the need for a guardian. For example, the Human Rights Officer and Post-Move Monitor met with QDDPs to review the processes currently in place that could assist teams in beginning to better define individuals' decision-making capacity. These included the Rights Assessment, Functional Assessment, and Psychological Assessment processes. Based on interview, the training emphasized the need for teams to better complete the consent section within the Rights Assessment using information from these other two documents. Although these were good initial steps, it was anticipated that the State Office policy on	

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		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. In order to assess teams' adherence to the expectation that they discuss individuals' decision-making needs, the Facility had included some indicators on the tool used to monitor ISP meetings specifically related to consent. Three indicators addressed the team process of discussing the individual's current guardianship status, need for an advocate, and ability to provide informed consent. An indicator also was added to determine if teams were discussing guardianship with families at the ISP meetings. This was a positive addition. Based on the Monitoring Team's review of ISPs, although teams often identified that individuals did not have guardians and had difficulty with decision-making, the discussion appeared limited. In the ISPs reviewed, teams made no delineation of an individual's priority need for a surrogate decision-maker, and little planning appeared to occur in relation to alternatives to guardianship or identifying potential guardians. More specifically, in reviewing 10 ISPs, which are identified in the documents reviewed section, the following was found: ▪ Six of nine (67%) had a guardian appointed. Of note, Individual #184's guardian was identified as having limited involvement due to health concerns. However, the team did not discuss the need for planning in relation to a successor guardian. ▪ Three of the remaining three (100%)included a discussion of the individual's need for a guardian. ▪ None of three (0%) included an adequate assessment of the individual's "functional capacity to render a decision regarding the individual's health or welfare." 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. 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. ▪ None of three (0%) included a discussion of the individual's priority factors for needing a guardian. As discussed in the Monitoring Team's previous report, 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. Using language taken directly from the Settlement Agreement, the Guardianship Coordinator had met with	

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		each of the IDTs on campus, and reviewed the teams' impressions of each individual's decision-making capacity, and using the criteria in what was the draft State Office policy at the time, 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. As noted in the last report, this was a substantial undertaking, and a good effort at further defining the priority list that LBSSLC had been maintaining. Based on the recently issued State Office policy, these activities appeared generally consistent with the requirements. However, as noted above, it was not clear from the ISPs reviewed that teams had continued to have these detailed discussions to determine if any changes had occurred that would impact the individual's need for guardianship or priority rating. Even though it was not clear from the ISPs reviewed, the Human Rights Office indicated that as teams identified changes, she was notified, and as individuals were admitted to the Facility, she participated in the review described above with the individual's team. Using this information, the prioritized list was updated on at least an annual basis. The updated prioritized list included names of 92 individuals served by LBSSLC. At the time of the review, Lubbock supported 220 individuals, of whom approximately 42% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 42 individuals had a Priority I need for guardianship, 42 individuals were in the Priority II category, and eight were in the Priority III category. As discussed during the onsite review, 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; 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 work with its QDDPs to help them to better understand	

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		the benefits and limitations of guardianship, and the current assessments that might contribute to a fuller assessment of an individual's functional decision-making capacity.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	According to documentation and interview with staff, since the previous monitoring visit, eight 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 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 two individuals. As noted above, the list provided by the Facility showed that a total of 92 individuals of the 220 individuals served by the Facility (42%) 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. The Monitoring Team's previous reports illustrated many of the 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. As noted above, the Human Rights Officer/Guardianship Coordinator had provided training to the QDDPs on guardianship. According to the training agenda, QDDPs' roles in educating families about the roles of advocates and guardians, as well as helping to break down misconceptions about guardianship were discussed. The QDDP and IDTs' roles in providing information to interested family members or primary correspondents, as well as identifying potential guardians also was part of the discussion. This was a good initial step in involving teams more in the process of assisting to identify decision-making support, including guardians. Since the last review, another success that the Facility had was in working with the Family Association to set up a fund to assist with guardianship costs for individuals for whom payment of the associated fees and expenses would potentially prohibit them from obtaining a guardian. Facility staff were in the process of developing an application form, and working with the Family Association to finalize the process that would be utilized to review and approve applications. The Family Association and the Facility should be commended for this joint effort that should assist greatly in obtaining guardians for individuals who need them. 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	Noncompliance

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

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

1. The State should finalize the State Office policy on 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.); and
    c. 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. Given that the State Office issued its Guardianship policy, LBSSLC should review it, modify its policies as necessary, and implement portions of the policy that can be implemented without further guidance from the State Office. (Section U.1)
4. Once the State policy on consent is finalized, LBSSLC should modify its policy on guardianship to reflect the State policy. (Section U.1)
5. 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)
6. Based on any additional information included in State's Guardianship policy regarding determination of an individual's capacity to make decisions and the prioritization for guardianship, LBSSLC should review its procedures and determine if any changes need to be made to the list that identifies individuals who need the support of a guardian, and re-constitute the list, as needed. (Section U.1)
7. 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; 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)

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: o **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 Table of Contents for Active Record Quail, revised 1/31/12; o Master Record Index, undated; o Individual Notebook TOC and Guidelines, revised 1/31/12; o Quality Assurance checklists for last 10 records reviewed, various dates; o In response to request for plan of correction resulting from record audits, the statement: "no corrective action plans done from record audits;" o In response to request for follow-up regarding corrective action plans, the statement: "No follow-up conducted for corrective action from record audits;" o List of new or revised Facility procedures since 8/25/12; o List of procedures reviewed by Operating Procedures Manual (OPM) Review Committee and approved with revisions, dated 2/14/12; o List of procedures submitted for OPM Review committee review/approval but have not been reviewed, dated 2/14/12; o Other Policies, undated; o Communication regarding policies changes, including emails with various dates; o Presentation Book for Section V; o Section V Presentation LBSSLC Monitors' 4th Compliance Visit, March 2012; o Draft Corrective Action Record Deficiency Tracking Process, dated 3/9/12; o Description of Quality Assurance Procedures and Process for Selecting Records for Review, undated; and o National Association for Information Destruction Certification manual, dated January 2011. o **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: Based on a review of the Facility's Self-Assessment with regard to Section V of

	the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. Since the Monitoring Team's previous review, the Facility had begun to make improvement in the justification it offered for its findings. Over a short period of time working with a new format from State Office, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating based on the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted: ▪ In general, the activities cited appeared reasonable. However, elements were missing. This resulted in key components of the Settlement Agreement not being assessed. For example: o The results of the Facility's regular record audits should be included in Section V.1 to provide information about the adequacy of individuals' Active and Master Records, and their Individual Notebooks, including compliance with the guidelines included in Section D of the Settlement Agreement. o With regard to Section V.2, no assessment was provided of the status of staff's training on the new or revised policies and procedures. o With regard to Section V.3, the Facility assessed whether or not was completing the required record reviews. The Facility also cited its new process for addressing issues identified in individual record reviews. This was positive, but the Facility also should assess if analyses of the data were being used to improve the system on a systemic level. o For Section V.4, the Facility had not yet begun addressing each of the components that the Monitors and parties agreed were necessary for compliance with this provision. ▪ Inter-rater reliability will need to be formally established between the Unified Records Coordinator and Lead File Clerk. This is discussed in further detail with regard to Section V.3. Overall, the Facility had demonstrated that it was beginning to incorporate some of the data it had collected into its self-assessment process. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section V is discussed in further detail below with regard to Section V.3.
	Summary of Monitor's Assessment: Since the last review, the Facility had made progress in a number of areas in relation to recordkeeping. For example, a new Medical Records Clerk had begun to reorganize the Master Records, and this time-consuming project was approximately half way completed. To improve the security of records, secure bins had been purchased and placed in open copy rooms. The Unified Records Coordinator had begun providing training on recordkeeping at New Employee Orientation (NEO). With the implementation of the procedure for the submission and filing of documents in the Active Records now completely underway, improvements were noted in the availability of documents in records, and greater accountability had been established. Similarly, the process for checking out the Active Records also appeared to have had a positive impact.

	As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. Some of the issues that staff verbally identified included legibility, gaps in records, and the inclusion of the most current information in the record. To begin to address this on an individual record basis, the Unified Records Coordinator had drafted a process for a Corrective Action Record Deficiencies Tracking Process, dated 3/9/12. It set forth a reasonable process for notifying responsible persons for concerns noted through record audits and following up to ensure corrections were made. The process was schedule for implementation beginning 4/1/12. Based on documentation provided, 34 procedures were developed or revised since the previous compliance review. The OPM Committee had reviewed and approved with revisions an additional six. An additional 10 were pending review and approval. In addition, seven Clinical Guidelines has been developed. 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. 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. 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 completeness of the records, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As noted in 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: ▪ One Unified Records Coordinator, a Lead File Clerk, four File Clerks, and a Medical Records Clerk continued to be assigned to the Quality Assurance Department. Their primary responsibilities related to the maintenance of records. At the time of the Monitoring Team's last review, the Medical Records Clerk was vacant. Since then, a new Medical Clerk had been hired, and had made	Noncompliance

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		significant progress in better organizing the Medical Records room and files. ▪ The new Medical Records Clerk had begun the process of adding the Table of Contents to each of the Master Records, and better organizing and labeling the records. This was a significant undertaking. At the time of the review, about half of the records had been reorganized. ▪ Efforts had been made to better ensure the security of protected health information. Specifically, to help to ensure that information from printers and copies were properly disposed of, secure bins had been obtained for open copy rooms. On 1/27/12, supplies were purchased. In early February, an email explaining the use of the boxes was sent to all staff, and the boxes were placed in the designated areas. A process was in place for individuals and staff from the Work Center to retrieve the contents of the bins and return it to the Work Center for shredding. Already, the need for larger bins in some areas had been identified, and purchases made. ▪ In addition, the Quality Assurance Director had worked with the Competency Training and Development Director regarding the initiation of training in NEO regarding proper recordkeeping practices and proper submission of information for fining in the Active Record. It was agreed that the Unified Records Coordinator would provide this training as part of NEO. In March 2012, the Unified Records Coordinator had begun to provide the hour-long training session. Based on the course outline and the PowerPoint presentation, it appeared to be comprehensive, but easy-to-understand training. It included a written test at the end. As discussed while on site, it should be helpful for staff to have this information from the beginning of their employment with the Facility. ▪ The Unified Records Coordinator, Medical Records Clerk, and Lead File Clerk attended training with State Office. This included working sessions as well as training, and covered many topics, including minimal guidelines for Master Records, development of processed for Monitoring Section V.4, electronic records, record security, etc. ▪ At the time of the review, staff reported that each individual continued to have an Active Record, a Master Record, and an Individual Notebook. ▪ As noted in the Monitoring Team's last report, 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 and the related efforts appeared to have been significant. Based on the records reviewed, the time stamps that indicated dates on which items had been filed were clearly present. This process appeared to have improved the accountability for the timely filing of documents in the records. Areas in which improvements should be made in order to achieve compliance, included:	

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		▪ 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. To begin to address this on an individual record basis, the Unified Records Coordinator had drafted a process for a Corrective Action Record Deficiencies Tracking Process, dated 3/9/12. Essentially, it described a process for ensuring that once deficiencies were identified in records through the audit process, this was communicated to the responsible party, and action was taken to correct the issue. The infrastructure of the tracking log allowed information about the deficiency to be entered once, and an email sent to the responsible party. In addition, the system would flag the due date to make follow-up easier. The system also would allow information to be aggregated to assist staff in identifying potential systemic issues. The QA/QI Council had approved it, and implementation was scheduled to begin on 4/1/12. Although this system remained in the initial stages, it should be helpful in ensuring necessary corrections are made. ▪ As noted in the last report, 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. ▪ The Facility continued to implement the procedure for signing records in and out of the residences. The policy was entitled: Active Record Check Out/Check In Process, dated 6/10/11. However, according to the Facility's Self-Assessment, data from January 2012 showed that only five out of 15 residences had properly checked out records. 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.	

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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, 34 procedures were developed or revised since the previous compliance review. The OPM Committee had reviewed and approved with revisions an additional six. An additional 10 were pending review and approval. In addition, seven Clinical Guidelines has been developed. Comments on a number of these policies are 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	Noncompliance

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		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 during the previous review 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 Training and Development 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	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ As during past reviews, 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. ▪ As previously reported, beginning on 1/1/11, LBSSLC began using the monitoring review tool the State Office developed entitled Recordkeeping and	Noncompliance

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	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.	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. 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. As noted above with regard to Section V.1, the Facility was at the beginning stages of implementing a process to correct issues identified in individual records. The Corrective Action Record Deficiencies Tracking Process, dated 3/9/12, provided what appeared to be a reasonable approach to requesting and tracking follow-up action to close the loop on issues identified. The Facility recognized that the next step in the process was reviewing aggregate data, which the new system developed for the tracking process would be able to produce, identifying potential systemic issues, analyzing the data, and developing corrective actions, as appropriate, to address them. However, at the time of the review, this had not yet occurred. Although efforts were being made to establish inter-rater reliability between the Unified Records Coordinator and the Lead File Clerk, the reviews they were conducting of the same record reportedly occurred between a day and two days apart. Given the ever-changing nature of the record, as well as the tendency to make easy corrections to the records as reviews were completed, in order to establish inter-rater reliability for this type of monitoring, both auditors would need to review the record simultaneously. 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	Recently, the Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. LBSSLC just recently had become aware of this at the meetings with the State Office. As a result, staff had not incorporated this structure into their internal monitoring. The following represent the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although LBSSLC was	Noncompliance

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	decisions.	not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted in the Monitoring Team's last report, to address issues related to the timely filing of information needed to make decisions, a specific 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 and the related efforts appeared to have been significant. Based on the records reviewed, the time stamps that indicated dates on which items had been filed were clearly present. This process appeared to have improved the accountability for the timely filing of documents in the records. However, as the Facility's monitoring activities showed, some issues continued to exist with the timely availability of documents in Active Records. The new system was helpful in identifying where problems had occurred, increasing accountability. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o 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 accurately, consistently, and timely documenting data, and processes were not in place to ensure data reliability. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** The Unified Records Coordinators were asking a sample of team members to complete the questions that State Office had sent related to Section V.4. Review of a small sample of these completed forms generally showed that staff were able to articulate how they used the records. Based on discussions with Record Department staff, sometimes, team members included recommendations to improve the records. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** The Facility had not yet developed a process for incorporating information regarding the use of records during relevant meetings into the database for Section V.4. As discussed in previous reports, this should include observations of a variety of meetings in which	

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		information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.). The Unified Records Coordinators might not do this, but such indicators might be distributed in other monitoring tools, and the data fed back to the Records Department. Based on the Monitoring Team's observations: o Continued emphasis was needed on using records for decision-making purposes. For example, ISP meetings during the week of the Monitoring Team's review, staff were observed trying to remember facts. The records should have been used to inform the teams' deliberations. o As discussed with regard to Section F of the Settlement Agreement, ISPs continued to lack evidence of teams making data-based decisions. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

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. 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)
3. 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)
4. 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, ISP meetings, etc.), and reviewing documents

such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinator and Lead File Clerk, but might be distributed in other monitoring tools. (Sections V.3 and V.4)

5. 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)
6. 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)
7. As the Facility's self-assessment processes continue to evolve, the Self-Assessment should include more information related to the analyses of data collected through the internal audit processes. (Facility Self-Assessment)

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
ABLLS	Assessment of Basic Language and Learning Skills – Revised
ADA	American Dental Association
ADL	Adaptive Living Skill
ADOP	Assistant Director of Programs
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
BACB	Behavior Analyst Certification Board
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
BMP	Basic Metabolic Panel
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
CRIPA	Civil Rights of Institutionalized Persons Act
CPR	Cardiopulmonary Resuscitation
CT	Computed tomography
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cardiovascular Accident
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
FTE	Full-time Equivalent
GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G/J-tube	Gastrostomy/Jejunostomy Tube
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
Hgb	Hemoglobin
HIPAA	Health Insurance Portability and Accountability Act

HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HRO	Human Rights Officer
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
LD	Licensed Dietician
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
NEC	Not Elsewhere Classified
NEO	New Employee Orientation
NM	Nutritional Management
NMT	Nutritional Management Team
NOS	Not Otherwise Specified
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 (Registered)/Therapy
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
PMH	Past Medical History
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
PSA	Prostate-Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist/Therapy
PTA	Physical Therapist Assistant
QA	Quality Assurance
QA/QI	Quality Assurance/Quality Improvement
QAM	Every morning
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Reviews
QE	Quality Enhancement
QID	Four times a day
QMRP	Qualified Mental Retardation Professional
RC	Residential Coordinator
RCA	Root Cause Analysis
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 Program
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
SL	Speech Language
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
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TSHA	Texas Speech Language Hearing Association
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UAD	Unauthorized Departures
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