United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Review: October 1, 2012 through October 5, 2012

Date of Report: January 9, 2013

Submitted By: Maria Laurence, MPA, Monitor

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

Table of Contents

I. Background

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

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

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

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

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

II. Methodology

In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.
(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

III. Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

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

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

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

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

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

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

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

IV. 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 Lubbock State Supported Living Center (LBSSLC) had taken many steps to address issues that had been identified during previous reviews, and had a strong commitment to comply with the Settlement Agreement. At each visit, evidence was found of continued development of a strong team that recognized the need for methodical and steady progress. At LBSSLC, a number of key steps had been taken and the infrastructure continued to grow. As noted after the last review, the change that was occurring was meaningful change that was resulting in improved supports for the individuals living at LBSSLC.

As discussed in further detail below, the Facility was committed to a continuous quality improvement process that involved people throughout the organization. This continued to be evident through the Facility Director's strong leadership during the Quality Assurance/Quality Improvement meetings, as well as in conversations with staff throughout the organization.

At this point in the life of the Settlement Agreement, the challenge remains for the Lubbock team 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 Lubbock State Supported Living Center's status with regard to relevant sections of the Settlement Agreement:

<u>Restraints</u>

- With regard to the use of restraint, there were a number of very positive accomplishments noted during this recent site visit. As has been the case since the baseline visit, there had continued to be heightened awareness of the limitations of restraint and a very decisive attempt to reduce its use through the introduction of less intrusive interventions. Restraint use was examined continuously through a number of varied methods, including priority attention at the daily Incident Management Review Team meetings attended by the Facility's leadership, collaborative efforts to ascertain any connecting links to injuries and incidents, and consistent efforts by the Director of Behavioral Services to introduce more positive approaches and to offer consultation and support to residential staff.
- 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. However, at the same time, opportunities again 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. In addition, a number of protections related to ensuring individuals were safe and restraint was properly used were still in need of improvement. For example, physicians were not routinely documenting a schedule for monitoring medical restraint, information about what happened before the restraint often was not adequate, and nursing staff were not properly assessing individuals that had been restrained.

- The Facility has accomplished a number of the obligations that can lead to compliance with the Settlement Agreement. However, the most difficult challenge remained. Individual Support Plans must be designed and implemented so that more restrictive interventions can be replaced with more individualized and socially integrated opportunities to learn and practice acceptable behavior.

Abuse, Neglect and Incident Management

- The leadership and staff of LBSSLC are to be strongly commended once again for their unrelenting commitment to zero tolerance of abuse, neglect, and exploitation. There were repeated examples of disciplinary action, including dismissal, taken against employees who had violated the rights and protections of the individuals under their care. The investigation process itself had been strengthened by the expedited commencement of the investigation, within the first twenty-four hours, and consistent adherence to timeframes for the completion of the investigation reports. The Incident Management Coordinator and his staff had worked diligently to respond promptly and efficiently to the notice of an allegation. In addition, there appeared to be a clear understanding of the investigation protocols, and there was a detailed system for tracking the requisite actions. The review of thirty-one investigation reports found that, in general, both the DFPS and Facility reports were succinct yet thorough. However, some concerns were noted with regard to the basis for the conclusions in Facility investigations. In addition, as cited in past reports, concerns still were noted with regard to DFPS and Facility investigators' review of the previous history of alleged perpetrators and victims.
- Since the Monitoring Team's last visit, the Incident Management Coordinator had implemented systematic methods for data collection and analysis. In several forums, including the Quality Assurance/Quality Improvement Council, his work was discussed in combination with the analyses of restraint and injuries the Director of Behavioral Services and the Risk Manager compiled. The compilation of this information had begun to contribute to a deeper understanding of the nature of risk at LBSSLC, and the need to design and implement creative, yet practical, solutions to significantly entrenched problems. The development of a database to track and address peer-on-peer aggression was one example of the creative problem-solving underway. As this work evolves, it will be critical that sustainable interventions be secured through staff training, increased activities for habilitation, and improved living environments. The unacceptably high turnover of direct support professionals in the residential areas had complicated these initiatives. However, the Facility's serious attempts to understand and address the causes of staff turnover were noted by the Monitoring Team.
- Although Section D was not found to be in full compliance with the provisions of the Settlement Agreement, continued progress was recognized. As a result, the Facility's focus on the development and implementation of

accurate databases, the analysis of trends by individual and by residential unit, and the identification and replication of positive practices that had eliminated some injuries and other serious incidents continued to merit the time and energy of all staff working at LBSSLC.

Quality Assurance

- Since the Monitoring Team's last visit, the Facility continued to take action to strengthen the Quality Assurance process and to ensure that leadership staff and the members of the Quality Assurance/Quality Improvement (QA/QI) Council reviewed subsequent findings on a periodic basis. Clearly, the design and implementation of an effective and sustainable quality assurance process remained a priority at LBSSLC. Although still incomplete, there was evidence that the Facility had implemented a number of monitoring and evaluation strategies in order to achieve compliance with the outcomes of the Settlement Agreement.
- The role and value of an effective Quality Assurance Department seemed better understood on a Facility-wide basis. As a result, there was a notable level of cooperation and collaboration expressed to the Monitoring Team during the course of the onsite visit.
- One of the primary concerns noted during the onsite visit continued to be the lack of established key indicators and/or outcome measures. According to information obtained during the review, in July, the State Office assumed responsibility for the determination of the final set of key indicators and/or outcome measures. However, this work had not been finalized and the Facility was unable to provide a status report or a timeframe for completion. The failure to determine a set of key indicators will most certainly affect the Facility's ability to move forward with its establishment and implementation of a comprehensive quality management system.
- Review of the monthly minutes of the Quality Assurance/Quality Improvement Council and attendance at one of its meetings continued to demonstrate the importance and effectiveness of this organizational structure. The agendas consistently focused on achievement of compliance with the provisions of the Settlement Agreement. Corrective Action Plans (CAPs) were identified, refined, and tracked. Changes in the CAPs required discussion and consensus. As a result, there appeared to be a more deliberative approach to problem identification and resolution. The discussion was enriched by the depth of knowledge about individuals and program processes held by some Council members. In addition, the combined presentation of related information, such as the data regarding incidents, injuries and restraint use, permitted a fuller perspective of the risk factors present at LBSSLC and, consequently, a more effective elaboration of remedial strategies. At the time of the site visit, the CAP Tracking Log documented that there were twelve remedial actions in the process of completion or continued monitoring.
- In summary, continuing progress in the development of a strong Quality Assurance system again was evident. The Monitoring Team commends the Facility's continuing efforts in striving to achieve compliance with these mandates of the Settlement Agreement. The Monitoring Team also reiterates its recommendation that the State Office proceed expeditiously to finalize key indicators and/or outcome measures, so that realistic and

appropriate goals and benchmarks can be established at the Facility and aid its intent to reduce risk and strengthen habilitation and protection from harm.

Integrated Protections, Services, Treatments and Supports

- In August 2012, the State Office provided additional training on a revised Individual Support Plan (ISP) format and process to LBSSLC's Qualified Developmental Disabilities Professionals (QDDPs) and many other team members. A revised ISP Meeting Guide was introduced. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. In addition to the team using a new tool to identify the individual's preferences, strengths, and priorities, the team also was to make decisions regarding which team members should attend the annual meeting, and the assessments that needed to be completed prior to the meeting.
- At the time of the Monitoring Team's review, two teams had been selected to pilot the new process. Other teams were using a portion of the process, but had not yet fully implemented the revised Integrated Risk Rating Form (IRRF) or integrated health care plans (IHCPs). For the pilot teams, the first meetings using the new process were held the week of the Monitoring Team's review. Beginning with a couple more teams in January 2012, LBSSLC planned to slowly rollout the full process, using the pilot teams as mentors.
- LBSSLC had developed QDDP Mentoring Quads. They appeared to be a good addition and provided support to QDDPs by involving other QDDPs in taking detailed notes during ISP meetings, and giving QDDPs time to quickly turn around the ISP documents.
- As part of the ISP Preparation Meetings, teams had begun to more systematically identify the assessments that the individuals required. However, justification was not consistently provided when an individual's needs indicated the need for an assessment, but the team decided not to require completion of that assessment. Timeliness and quality of assessments continued to be problematic.
- The major focus of the ISP meetings the Monitoring Team observed was the risk rating and health care plan development. This is important, but teams will need to find ways to become more efficient with this process, and spend more time developing plans to assist individuals to become more independent and lead full and meaningful lives.
- The quality of teams' discussions about individuals' preferences and strengths, as well as community activities varied, particularly for individuals with more complex needs. Overall, further refinement of these discussions was needed.
- The Facility identified that the development of action plans was an area in which more work was needed, as well as more training and technical assistance. Based on limited observations of ISP meetings while the Monitoring Team was on site, teams were talking more about the various "protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual," and more interdisciplinary collaboration was occurring. Teams clearly were trying to develop measurable action plans, but needed assistance in developing comprehensive plans, as well as measurable and functional objectives. Although the

Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs.

- The Facility had developed a new monthly review format for QDDPs. It was positive that this review included more data related to skill acquisition plans. However, it remained unclear how the Facility would meet the specific requirement for review of each program or support, and appropriate action, if a lack of expected progress was noted.

Integrated Clinical Services

- The provider morning meeting was an interdisciplinary forum at which many areas of clinical care were reviewed. It also was a forum to share clinical topics of importance, often in the context of providing training and education.
- To provide a baseline of evidence for integrated clinical care, each department's attendance at the provider morning meeting was tracked. Additionally, a system had been created to assign concerns identified at the provider morning meeting to a member at the meeting, or to the Interdisciplinary Team (IDT). These concerns were tracked to closure, and often required written documentation. The morning provider meeting team also provided guidance to the IDT on the concern that needed to be addressed usually by putting it into the context of a challenge identified with regard to the care of an individual. The QDDP Educator attended this meeting and provided guidance to the QDDPs in addressing the concerns through the IDTs. Other departments reported periodically to this committee, such as the skin integrity committee, the laboratory technician, and the Physical and Nutritional Management Team (PNMT).
- To ensure consultant recommendations were integrated into clinical care, the Medical Department tracked the Primary Care Provider's (PCP's) review of these reports, as well as the timeliness of the review. Documentation of the PCP's agreement or not concerning the recommendation also was tracked.
- The challenge in demonstrating integrated clinical care was several-fold. Maintaining the efficiency and breadth of the provider morning meeting to demonstrate sustainability will be important. From the Monitoring Team's review, the IDTs needed continued guidance and accountability, and an expansion of open record reviews to determine early signs and symptoms helpful in treating illness at an early stage. Documentation of interaction between the PCP and the PNMT at PNMT meetings needed improved tracking. For the Individual Support Plan Addenda (ISPAs) that were the written response to a concern assigned to the IDT, there was need to determine if the provider morning meeting participants agreed or not with the ISPA (i.e., did it satisfactorily answer the concern). As the consultant recommendations are important to integrated care, there should be a process in which the consultant reports are reviewed by the IDT. However, it was not clear if there was a well-defined system in which consult recommendations were forwarded to the IDTs, and the IDTs reviewed these and documented review and discussion in ISPAs.

Minimum Common Elements of Clinical Care

- The Facility had made some progress with this section. For Sections L, N, and Q, the determination of completion of annual examinations within 365 days or on a quarterly basis, as applicable, was available. As a measure of minimal common elements of clinical care, attendance at the annual ISP also was tracked. The medical management medical peer review also addressed minimum common elements of clinical care. A record audit for one individual was provided as an example of identifying clinical areas essential to care. Such reviews should be translated into clinical measures and tracked over time. The Medical Department had created additional internal quality indicators. However, this was at the beginning stages of implementation, because the database was being developed and implementation of the monitoring had not occurred.
- Medical diagnoses appeared to have appropriate criteria to justify the diagnosis. As a result, the Facility remained in compliance with Section H.2.
- A challenge to the Facility was to have the various annual assessments available through a shared drive in preparation for the ISP meeting. This information was used to develop the ratings of the various risk categories in Integrated Risk Rating Form (IRRF). However, there appeared to be a delay in getting completed assessments into this system. The Medical and Dental Departments demonstrated timely completion of annual assessments based on the prior annual date of completion. However, these did not appear to be posted in the shared folder in a timely manner. This negatively impacted teams ability to be fully prepared for ISP meetings
- There remained a lack of evidence of tracking for some aspects of minimum common elements of clinical care. Taking a specific diagnosis, defining the required disciplines needed to ensure quality care, as well as the required consultations or spectrum of consultations, lab orders, medications, etc., and determining the provision of these treatments and services to a sample of individuals with the diagnosis would provide such evidence. Additionally, tracking evidence of minimum common elements of clinical care for acute care, chronic care, preventive care, and wellness care, would assist in providing necessary evidence.

At-Risk Individuals

- Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that would be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition (APEN) was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status.

- In July 2012, two teams at LBSSLC had been trained on the new policy and processes, and during the week of the Monitoring Team's onsite review, had begun to pilot them. One team supported individuals with medically complex issues and the other team supported individuals with psychologically complex issues. It was important that the new system was being piloted with two teams to determine any additional implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRFs indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing consistency across campus and improving the quality of the process. Until now, the quality of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at LBSSLC.
- From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and overall, more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of revisions to the IRRFs, dates of revisions, measurable and/or observable objectives, and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

<u>Psychiatric Care and Services</u>

- The Facility recently had added a new full-time Psychiatrist, who was going through the orientation process at the time of the Monitoring Team's review. The Director of Psychiatry's analysis of time requirements concluded that two full-time Psychiatrists should be sufficient to provide services to the 122 individuals who received psychotropic medication at LBSSLC.
- The Facility clearly had responded to the recommendations made in the Monitoring Team's previous report. This was evident in the progress in relation to many of the 15 provisions of Section J of the Settlement Agreement.
- At the time of the Monitoring Team's previous review, the Psychiatry Department had revised the content of the Comprehensive Psychiatric Assessments (CPAs) to better conform to the requirements of the Settlement Agreement. At the time of the current review, the Facility reported they had been completed for 100% of the individuals prescribed psychotropic medications. With two full-time Psychiatrists, and the Consulting Psychiatrist continuing on four hours per week to assist with the CPAs, it should be possible to update these on an annual basis for all of the individuals who receive psychotropic medication.

- At the time of the previous review, the Psychiatry Department had developed a system to facilitate the timely completion of the various steps in the desensitization process, which subsequently had been implemented. At the 10/4/12 meeting, the Behavioral Services Department reported that "Skill Acquisition Plans" had been completed for all of those individuals who require them for medical or dental procedures, and these plans were in various phases of implementation.
- 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. It will be important to fully document the contribution of Psychiatry to the ISP process.
- Another issue 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. This gave the impression the medication was being used to suppress a learned behavior. The Psychiatry Department had responded to this with thorough discussions in the CPAs and elsewhere in the records, and the Department of Behavioral Services now had added a discussion to address this in the Functional Analysis. These interventions had effectively addressed this problem.
- Progress regarding reductions in polypharmacy continued. The Psychiatry Department had created three subcategories based on comments 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 individuals whom teams believed required their existing medication to maintain their stability. The Facility had assembled empirical historical data to substantiate the efficacy of the medication for many of the individuals they believed required continuation of their medication. The third category was labeled, "New Admissions," and tracked the progress of the individuals who had been admitted from the community on multiple psychotropic medications.

<u>Psychological Care and Services</u>

- Progress continued with regard to psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing. Two psychologists had completed all coursework as well as supervision requirements, three psychologists had completed all of the required coursework, and four psychologists were currently enrolled in coursework. These seven psychologists also were receiving necessary supervision.
- Consistent progress was evident in the current internal peer review system. However, similar progress in a sustained external peer review system was not as conspicuous. Improvement continued in the implementation of monthly Positive Behavior Support Plan (PBSP) progress notes, including the use of effective graphing conventions. However, concerns remained regarding their timely completion. In addition, it was not evident that these progress notes were utilized to facilitate data-based decision making, particularly with regard to revising behavioral programming.
- Progress was noted with regard to the completion of comprehensive psychological evaluations, including formalized standardized testing, as well as in the timely completion of psychological assessment updates.

However, the majority of individuals continue to have outdated standardized tests of intelligence and adaptive behavior. Since the Monitoring Team's previous visit, improvement in the development of quality functional assessments and counseling supports was also evident. In addition to addressing remaining areas of concern, these improvements will need to be available to all individuals served by the Facility, as appropriate.

- Continued improvement in the quality of PBSPs was observed, and work continued to make the additional improvements necessary. In addition, progress was evident in the completion of inter-observer agreement (IOA) probes as well as competency/integrity checks. In addition, issues surrounding the adequacy of training, including competency based training for part-time or pulled staff, as well as the development of systems to comprehensively monitor these trainings remained a concern.

Medical Care

- The Medical Department had made progress in a number of areas. The format of the provider morning meeting was a mature structure through which numerous aspects of medical care were discussed and processed in an efficient manner, and areas of concern identified, assignments made to either members of the meeting or to the IDTs, and closure of these tracked. Observation of these meetings and a review of the minutes over a several week period provided a level of confidence that closure was occurring for identified concerns. However, observation of the morning meetings indicated that critical review of potential steps to prevent recurrent hospitalizations or Emergency Room (ER) visits remained an area needing improvement. Open record reviews would assist in resolving this area of need.
- There also has been progress in a number of databases, such as osteoporosis, mammograms, and colonoscopies, necessary to ensure individuals received adequate preventative care. The Medical Department was in the early stages of determining an audit process and database for clinical indicators of diagnoses/ hospitalizations/ER visits that would be collected in addition to the external and internal peer review clinical indicators. However, some challenges remained. The Monitoring Team's record reviews indicated compliance with quarterly medical reviews was greater than the database indicated, suggesting information was not being returned to the medical administration for entry into the database.
- Tracking of Physical and Nutritional Management Team (PNMT) recommendations through to PCP orders remained in the early stages of implementation. Determining the cause of missed appointments remained an area that needed an improved system of information retrieval. In addition, measurable clinical indicators should be created for all the aspects of care for Section L. It will be important to maintain the success that had occurred in creating monitoring systems, while efficiently adding monitoring components to identify areas that would benefit from improved quality.

Nursing Care

- Since the last review, nursing staffing continued to be a significant challenge for the Facility, with turnover in a number of positions as well as in the key leadership nursing positions. Due to these staffing issues, the Facility had to utilize Agency nurses to cover some of the vacant positions, and continued to do so at the time of the

review. In addition, LBSSLC had some changes regarding the Nursing Department and nursing positions. For example, a new Chief Nurse Executive was appointed in May 2012; a new Nurse Operations Officer was hired in June 2012; a full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position in August 2012; a new full-time Hospital Liaison was appointed in July 2012; an Assistant Nurse Educator was hired in July 2012; and the existing Nurse Educator (RN) moved to a position as the Quality Assurance Nurse in May 2012.

- Some of the Facility's positive steps forward included:
  - An administrative nursing on-call rotation was developed and implemented;
  - Job expectations were reviewed with Case Managers and Shift Supervisors;
  - 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.
  - Protocol Stickers were implemented in July 2012 to prompt nurses to conduct and document the appropriate clinical assessments for specific health issues. In addition, the Facility had also implemented nursing protocol audits in August 2012.
  - The Facility continued to utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues.
  - On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in Quail, Sparrow, and 514 Birch found that all staff were familiar with the use and operation of the emergency equipment, which was a significant improvement from previous reviews.
  - In August 2012, the Facility implemented a very positive procedure that included requiring the nurses to bring the Medication Administration Records (MAR) to shift change for the off-going and on-coming nurse to review the MAR for blanks and/or omissions.
- At the time of the review, nursing was focused on determining the baseline for a number of the nursing systems and Settlement Agreement requirements in order to develop a prioritized plan for moving forward. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, and the quality of the quarterly and annual Comprehensive Nursing Assessments were very concerning at this juncture in the review process. As candidly reported by the CNE and Facility Director, the challenges in stabilizing the nursing coverage related to staff turnover, and the necessary changes made in the nursing leadership positions since the last review had prevented the Facility from making more progress. However, it is the hope of the Monitoring Team that the time the Facility took to assess its nursing systems will result in an appropriately prioritized plan with sustainable positive systems and outcomes.

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

- The Pharmacy Department had been diligent in reviewing new orders in the several areas outlined by the Settlement Agreement (e.g., significant side effects, drug-drug interactions, appropriate dosage, laboratory monitoring, and allergies). Quarterly drug regimen reviews provided a review of a number of aspects of the

medications prescribed to individuals, and the Facility was consistently completing these reviews. Training of staff concerning identification and reporting of adverse drug reactions had recently been completed. Drug utilizations appeared to continue to be completed in a timely manner. The Pharmacy Department also created a number of internal monitoring tools that were helpful to the department in ensuring compliance and identifying areas of need.

- Areas of need included tracking and monitoring timely completion of the pharmacy section of chemical restraint forms. A statement of effectiveness or not of the chemical restraint would provide additional guidance to the IDT. The Pharmacy Department had collaborated with the Nursing Department in resolving the challenge of medication variances. There has been progress in resolving documentation errors related to medication administration. The number of unexplained medications returned remained a concern, but the Pharmacy Department was involved with additional pilot programs to address this challenge. Over the past two years, the Pharmacy Department had been involved in several projects to resolve medication variances, but these efforts and their outcomes had not been summarized in timeline fashion. This would allow a historical perspective of gains made in this area, as well as areas still requiring attention.

<u>Physical and Nutritional Supports</u>

- The Facility PNMT Guidelines had been revised in August 2012, and these revisions were positive additions to provide further guidance to the PNMT and IDT members. However, the IDTs had not been provided training on the guidelines.
- The PNMT Nurse attended the daily morning provider meetings. This provided opportunity to update clinical staff on the status of individuals on the PNMT caseload, as well as present systemic issues for discussion and resolution.
- The PNMT had developed and implemented audit tools for the PNMT assessment and Follow-Up. These tools were implemented in August 2012.
- A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans, because multiple components were missing. On a positive note, through its self-auditing process, the Facility had begun to identify some of these issues itself.
- Lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate (i.e., individuals who require mealtime assistance, individuals at high and medium risk for physical and nutritional management (PNM) concerns, individuals who had difficulty swallowing). The Director of Habilitation Therapy (HT) acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists.
- Since the last review, the therapists had revised Physical and Nutritional Management Plans (PNMPs) to include individual-specific risks and triggers. This resulted in positive additions to the PNMPs. However, a review of the

list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP.

- The Monitoring Team and members of the PNMT team completed direct observations of the implementation of PNMP strategies in residences for individuals on the PNMT caseload. These observations revealed that some staff were, but others were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems.
- The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress.
- The Facility was in the process of implementing a new Aspiration Pneumonia Enteral Nutrition (APEN) process in conjunction with the new ISP process. However, the Facility was in the beginning stages of implementing it, and, at the time of the review, ISPs did not yet provide justification for the continued use of the tube as medically necessary, or identify the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

Physical and Occupational Therapy

- Individuals' Occupational Therapy/Physical Therapy (OT/PT) assessments were significantly improved from the last review. However, the assessments were still missing some essential components. A positive practice was the development of an OT/PT assessment audit tool, but the tool had not been implemented.
- OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports.
- Individuals with Physical and Nutritional Management Plans (PNMPs) and dining plans were not monitored at an established frequency with an emphasis on enhanced monitoring for individuals at high risk for Physical and Nutritional Management (PNM) concerns. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability, and effectiveness.

Dental Services

- The Dental Department had made some important strides. The new dental database was functional, and data could be obtained. The Facility's Self-Assessment contained results of data obtained through several databases from 2/1/12 to the present. The most recent annual dental examinations appeared to have updated odontograms. To minimize handwriting of the various dental progress notes, the Dental Department created a number of templates, specific to the reason for the dental visit.
- Areas remaining a challenge included the timely completion of annual exams, which was noted to be at 60%. There was a need to develop a departmental policy concerning the type of documents that should be available in the dental record for cases in which Total Intravenous Anesthesia (TIVA) was used (such as preoperative

anesthesia clearance, preoperative medical clearance if indicated, guardian consent, etc.). Desensitization plans appeared to be completed, but there was no information provided to demonstrate progress in implementing any plan. There continued to be a need for more information concerning the reason for missed appointments in order to begin to increase the rate of completed appointments. Dental summaries needed concise statements of the level of risk, tooth brushing instructions, and requirements and considerations for community preparedness, all areas important to the IDT ISP discussions.

- One challenge ahead will be taking the database information and using it to improve the quality of services. There were many areas that remained outstanding, and demonstration of progress in each of the above areas as well as others described in the narrative report will require innovation in the Dental Department, and some areas will require cooperation from other departments.

Communication

- Individuals' Speech and Language (SL) assessments were significantly improved from the last review. However, the assessments still were missing some essential components.
- Observations by the Monitoring Team and two Speech Language Pathologists (SLPs) noted an improvement in the presence of the individuals' alternative or augmentative communication (AAC) systems. In addition, some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC systems.
- Although the Facility's Communication Services policy included some important components, a number were missing. It did not include the following key elements: monitoring for the use of communication adaptive equipment in multiple environments (e.g., home, day program, and work); the process for identification, training, and validation for monitors; the process of achieving inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). Based on documentation provided, adequate monitoring was not occurring of individuals' AAC equipment or its use.

Habilitation, Training, Education, and Skill Acquisition Programs

- Progress was noted in the continued development of skill acquisition plans (SAPs) as well as in the training of staff in their development and implementation. However, although improved, concerns remained regarding the quality of these plans and how targeted needs were identified and documented. In addition, adequate SAP data collection and monitoring remained problematic. Reports reflected efforts to hire new SAP developers, develop curriculum and review tools to ensure the quality of SAPs, implement trainings, and develop a system to track their timely completion.
- Continued efforts were noted in conducting integrity checks of SAPs and engagement observations. However, concerns regarding staff's ability to accurately and reliably implement integrity probes and support adequate levels of engagement were observed. In addition, although improvements in on-campus attendance in vocational and off-home day programs as well as off-campus supported employment were noted, declines were reported in the number of individuals placed in off-campus enclave and competitive employment positions.

- Minimal progress was noted in the completion of quality and timely functional skills assessments (FSAs). Similar concerns were noted with the completion of quality vocational assessments, including the use of vocational explorations. However, reports reflected efforts in developing guidelines/training curriculum, quality review tools, and tracking systems to promote quality functional skills and vocational assessments.
- Slight progress was noted in developing SAPs designed to be implemented in the community. However, community outings, overall, had remained unchanged and minimal for individuals in some residential programs.

Most Integrated Setting

- As State Office required, for annual ISP meetings, many, but not all assessments included the assessors' recommendations regarding the individuals' potential to transition to the community. Some limited improvement was seen in relation to ISPs including a summary or conclusion with regard to the professional team members' joint recommendation of whether or not transition to a more integrated setting was appropriate. However, disagreements amongst professional members of the team were not consistently resolved, and some confusion existed about the role of professional team members in making a joint recommendation. Based on observations of ISP meetings, it was not clear that when developing a joint recommendation, the teams were using an interdisciplinary process and considering all team members' opinions about the various supports and services the individuals required, and resolving differences of opinion.
- Teams continued to struggle with the adequate identification of obstacles to referral. Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. Based on the Monitoring Team's review of action plans to overcome the obstacles, few included measurable action steps, and significant problems were noted with their quality and individualization. In addition, it was unclear whether or not the Facility was regularly reviewing and analyzing the data related to obstacles. As a result, it was unclear if the Facility had developed any plans or taken any action to address obstacles within its control.
- On a positive note, based on a call with State Office on August 28, 2012, in which the Admissions Placement Coordinator participated, the Level of Need for all individuals transitioning to the community from SSLCs during Fiscal Year 2013 were automatically increased to Level 6. This allowed community providers access to increased funds for meeting the individuals' needs. It was hoped that this might alleviate some of the obstacles to transition.
- Admissions and Placement Department and Transition Specialist staff were clearly working hard with individuals' teams to expand the scope and definition of pre-move and post-move required supports in individuals' CLDPs. Additionally, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. With regard to the

measurability of supports, this was an area that required attention, particularly as more complex supports were included in the plans.

- The Facility had been conducting pre-move monitoring, and this was resulting in better confirmation that pre-move supports were in place prior to the individual's transition to the community. However, as teams identified more extensive lists of pre-move supports, some concerns were noted with regard to the confirmation that such supports were in place.
- Post-move monitoring had been completed in a timely manner for the majority 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, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Although the Facility had taken some important steps to correct issues, the role of the individuals' teams in this process remained unclear, and, at times, the Local Authority and State likely should have been resolved in the resolution of issues.

<u>Consent</u>

- At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. LBSSLC was in the process of finalizing the local policy on guardianship, which essentially adopted the State Office policy with some minimal changes. Because the process that LBSSLC had used previously for individuals' teams to determine priority levels for guardianship largely mirrored the State Office policy, the Facility had not needed to redo this process. However, other aspects of the policy's implementation remained in the planning phase, such as the development of a Guardianship Committee, which ultimately would be the entity responsible for deciding upon the prioritization of the overall list of individuals requiring guardians.
- As a threshold issue, prioritizing an individual's need for guardianship cannot be done adequately until a process is in place to screen for an individual's need for a guardian. At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using an adequate standardized tool. LBSSLC had begun to complete some research on assessment used in other states as well as current assessments that teams could utilize in this process. Although it was positive that Facility staff were taking initiative, due to the complexity of this type of assessment, these efforts should be done in conjunction with State Office and other Facilities.
- The updated prioritized list, dated 9/27/12, included names of 80 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 38% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 37 individuals had a Priority I need for guardianship, 36 individuals were in the Priority II category, and seven were in the Priority III category.

- LBSSLC had continued to work mostly with the families of 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 four individuals in some phase of the process. However, since the last review, limited efforts had been made, such as working with State Office, to identify other potential guardianship resources. The Facility also was in the initial stages of re-developing a Guardianship Committee. This would be an important initiative, because, such a group, if properly constituted, might be helpful in identifying resources related to alternatives to guardianship, potential guardians, as well as funding to support individuals for whom the guardianship fees prohibit them from applying to become a guardian.
- One barrier to families becoming guardians on which the Facility continued to work was the funding needed to petition the court for guardianship. Facility staff had continued to work with the Family Association, which now had a subcommittee to review applications for funding for guardianship proceedings. In addition, the Guardianship Coordinator had worked with the Assistant Director of Administration on "waiver of board and care" to allow payment of guardianship costs.

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

- Since the last review, the Facility had continued to make process in relation to recordkeeping. For example, according to staff, the Master Records had all been reorganized. The Unified Records Coordinator continued to provide training on recordkeeping at New Employee Orientation (NEO).
- Based on the Monitoring Team's interactions with various departments, some concerns were noted with regard to the detail required on the Submission and Filing Tracking Sheets. Reportedly, this delayed the submission of important documents for filing. As was discussed with staff on site, it will be important to obtain feedback from various departments to determine any issues and develop reasonable solutions.
- The Operational Procedures Manual OPM had been made responsible for identifying staff that required training on policies, the timeline for completion of the training, the type of training required, the type of evidence required to reflect the completion of training, staff to whom the evidence needed to be returned, and the need for competency checks of staff knowledge following the training. Although information was being collected with regard to training on the policies, a structure was needed to make identification of staff that had not yet completed training a more efficient process.
- 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. Due to the systemic nature of some of the problems identified, the Facility had decided to retrain all staff on the Recordkeeping policy. At the time of the Monitoring Team's review, this training just had been completed. The Facility recognized that the next step would be aggregating and analyzing information gained through record audits in more depth to determine if more specific corrective action was needed.
- Based on observations of team meetings, teams were more consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. However, improvements

in this regard were still necessary. 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.

Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

For Sample #C.1, four individuals with a total of sixteen restraints were selected from lists the Director of Behavioral Services provided. Restraint records were requested, including Restraint Checklists, Face-to-Face Assessments, Debriefing and Reviews for Crisis Intervention Restraint forms, PBSPs, and for each restraint, the documentation of any and all reviews of this restraint information for the following individuals on the following dates and times:
<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th></tr>
<tr><td>Individual #22</td><td>5/4/12</td><td>5:05 p.m.</td></tr>
<tr><td></td><td>5/15/12</td><td>2:09 p.m.</td></tr>
<tr><td></td><td>5/27/12</td><td>6:53 p.m.</td></tr>
<tr><td></td><td>5/31/12</td><td>8:13 p.m.</td></tr>
<tr><td>Individual #27</td><td>8/9/12</td><td>5:42 p.m.</td></tr>
<tr><td></td><td>8/9/12</td><td>5:43 p.m.</td></tr>
<tr><td></td><td>8/10/12</td><td>6:00 p.m.</td></tr>
<tr><td></td><td>8/13/12</td><td>5:05 p.m.</td></tr>
<tr><td>Individual #61</td><td>7/10/12</td><td>5:16 p.m.</td></tr>
<tr><td></td><td>7/12/12</td><td>5:10 p.m.</td></tr>
<tr><td></td><td>7/24/12</td><td>9:56 a.m.</td></tr>
<tr><td></td><td>7/26/12</td><td>3:54 p.m.</td></tr>
<tr><td>Individual #124</td><td>8/6/12</td><td>12:55 p.m.</td></tr>
<tr><td></td><td>8/6/12</td><td>1:50 p.m.</td></tr>
<tr><td></td><td>8/9/12</td><td>11:29 a.m.</td></tr>
<tr><td></td><td>8/13/12</td><td>2:09 p.m.</td></tr>
</table>

For Sample #C.2, the following documentation was requested for a sample of 35 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;
For Sample #C.3, medical restraint documentation was requested for Individual #2 and Individual #284. Documentation for three episodes was provided;
Section C.4 sample included Positive Behavior Support Plans (PBSPs) for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201;
Individual Support Plan (ISP), Individual Support Plan Addendums for Restraints, and

</td></tr>
</table>

	Individual Support Plan (ISP) Action Plans, as provided, for: Individual #6 and Individual #321; o For Sections C.5 and C.6, restraint documentation completed by nursing staff for the following individuals: Individual #124, on 6/27/12 at 6:33 p.m., 7/16/12 at 11:17 p.m., and 8/13/12 at 2:00 p.m.; Individual #27, on 7/17/12 at 8:30 p.m., and 8/10/12 at 6:00 p.m.; Individual #288, on 6/9/12 at 8:41 a.m.; Individual #61, on 6/27/12 at 7:46 a.m., and 8/2/12 6:04 p.m.; Individual #31, on 4/26/12 1:45 p.m., 5/30/12 at 2:05 p.m., and 7/24/12 9:45 a.m.; Individual #2, on 7/31/12 8:20 a.m., and 8/1/12 at 7:40 a.m.; Individual #36, on 7/11/12 at 10:50 p.m.; Individual #143 on 7/31/12 at 11:30 a.m.; Individual #240, on 6/9/12 at 3:34 p.m.; Individual #57, on 8/8/12 at 12:56 a.m.; Individual #213, on 8/9/12 at 11:22 a.m.; Individual #60, on 7/21/12 10:20 p.m.; and Individual #284 on 8/1/12 at 6:10 a.m.; o Section C.7 sample was chosen from the list of individuals restrained as crisis intervention between 2/1/12 and 8/15/12. This included review of Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, Crisis Intervention Restraint Plans, Positive Behavior Support Plans (PBSP), Individual Support Plans (ISPs), ISP Addendums, and Monthly Behavioral Services Reviews (for the current month as well as the preceding and following months as well), as provided, for the following four individuals with restraints on the dates (times) specified: ▪ Individual #22 on 5/4/12 (at 5:05 p.m.), on 5/15/12 (at 2:09 p.m.), on 5/27/12 (at 6:53 p.m.), and on 5/31/12 (at 8:13 p.m.); ▪ Individual #27 on 8/9/12 (at 5:42 p.m. and 5:43 p.m.), on 8/10/12 (at 6:00 p.m.) and 8/13/12 (at 5:05 p.m.); ▪ Individual #61 on 7/10/12 (at 5:16 p.m.), on 7/12/12 (at 5:10 p.m.), on 7/24/12 (at 9:56 a.m.), and on 7/26/12 (at 3:54 p.m.); and ▪ Individual #124 on 8/6/12 (at 12:55 p.m. and 1:50 p.m.), on 8/9/12 (at 11:29 a.m.), and on 8/13/12 (at 2:09 p.m.); o List of restraints, from 2/12 through 8/15/12; o Presentation Book for Section C; o LBSSLC Policy, "Limitations of Restraint," revised 7/12/12; o Incident Management Review Team (IMRT) Meeting Minutes, from the first Monday of each week since the last site visit; o Restraint Reports for LBSSLC from 2/12 through 7/12; o Behavioral Restraint Report for 9/12; o Most recent "Do Not Restrain" list; o Completed Monitoring Tools for Section C; o Self-Assessment for Section C, dated 9/17/12; o Minutes of the Human Rights Committee, dated 3/29/12 through 9/12/12; o Minutes of the Quality Assurance/Quality Improvement Committee, dated 3/21/12 to 7/26/12; o For the last year, list of injuries by individual, living area, and by type; o List of injuries during restraint for individuals and staff, dated from 9/16/11 to 8/3/12;

	and o Settlement Agreement Compliance Reports for Section C, dated from 3/12 through 7/31/12. ▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs; o Jim Forbes, M.Ed, BCBA, Director of Behavioral Services; o Dawn Ripley, Director of Quality Assurance; o Rodney McWilliams, Incident Management Coordinator; o Tracey-Snow Murphy, Director of Residential Services; o Rodney Meeks, Unit I Director; o Jeremy Ellis, RN, BSN, Chief Nurse Executive; o Eddie McFadden, RN, Quality Assurance Nurse; o Ruth Clark, RN, Quality Assurance Nurse; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, M.S., BCBA; and George Zukotynski, State Office Coordinator for Psychology/Behavioral Services, on 10/3/12; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o Incident Management Review Team meetings, on 10/2/12, 10/3/12, and 10/4/12; o Executive Safety Committee meeting, on 10/3/12; o Quality Assurance/Quality Improvement Committee meeting, on 10/3/12; o Unit II morning meeting on 10/3/12; o Self-Advocacy Group meeting, on 10/3/12; and o Site visits to residences and the workshop/day program areas. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C, dated 9/17/12. In its Self-Assessment, for each subsection, 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. For Section C, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section C-Protection from Harm-Restraints." The Director of Behavioral Services also reviewed and analyzed the restraint checklists using a list of the requirements for completion of the restraint checklist included in the Settlement Agreement.

	○ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tools was consistent with the provision of the Settlement Agreement. ○ The monitoring tools included some adequate methodologies, such as the review of documentation. There was no indication, however, that other sources, such as the video camera footage, were employed. ○ The Self-Assessment identified the sample(s) sizes. However, it did not consistently, include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For example, the Facility provided the total number of individuals that had had more than three restraints in 30 days, and then identified the sample reviewed. However, this was not the case for most of the other sections. Although this was not specifically stated in the Facility's Self-Assessment, the Facility had decided that all restraints must be monitored and assessed for compliance with State and Facility policy. Thus, sample sizes were adequate to consider them more than representative samples. ○ The monitoring/audit tools provided during the site visit did not include instructions/guidelines. Therefore, the adequacy of the guidance to ensure consistency in monitoring and the validity of results could not be evaluated. ○ The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitors from the Quality Assurance Department worked collaboratively with Department staff to conduct the audits. Department staff positions were not identified in the documentation reviewed. During the site visit, interview with the Director of Behavioral Services confirmed the role he played in monitoring restraint use. ○ It could not be determined from the information provided whether all staff persons responsible for conducting the audits were competent in the use of the tools and whether they were clinically/programmatically competent in the relevant area(s). Clearly, the Director of Behavioral Services possessed the requisite expertise. ○ For Section C, no information was provided regarding inter-rater reliability. It could not be determined whether adequate inter-rater reliability had been consistently established between the various Facility staff responsible for the completion of the tools. This establishment of inter-rater reliability was a priority for the Facility. ▪ Did use some relevant data sources and/or key indicators/outcome measures. For example, in addition to conducting audits, the Facility used data sources such as its training database. However, key indicators of performance or outcome measures were not specifically cited. Topics for key indicators could be such things as the average length of time in restraint, the number of people restrained, the number of injury reports that are filed as a result of restraint use, the number of serious injuries that occur while an individual is in restraint, the number of people restrained off campus, number of individuals for whom restraint use has declined, etc. To develop key indicators, baselines and goals would need to be established, as well as methodologies and timeframes for collecting valid data. The Facility needs to decide what data they have and how to use it to provide an outcome measure(s) of their use of restraints. The point is that the Facility

	should not rely solely on data from audits, but include the analysis of outcome data in its Self-Assessment as well. ▪ The Facility consistently presented some of the data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Generally presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. For example, for Section C.8, the Facility looked at the timeliness of reviews of restraint, but not the quality. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section C: Section C.1, Section C.2, and Section C.3. This was not completely consistent with the Monitoring Team's findings. The Monitoring Team's did not find that the Facility was in compliance with Section C.1. ▪ The Facility data identified some areas in need of improvement. However, the Facility Self-Assessment did not provide a thorough 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.
	Summary of Monitor's Assessment: There were a number of very positive accomplishments noted during this recent site visit. As has been the case since the baseline visit, there had continued to be heightened awareness of the limitations of restraint and a very decisive attempt to reduce its use through the introduction of less intrusive interventions. Restraint use was examined continuously through a number of varied methods, including priority attention at the daily Incident Management Review Team meetings attended by the Facility's leadership, collaborative efforts to ascertain any connecting links to injuries and incidents, and consistent efforts by the Director of Behavioral Services to introduce more positive approaches and to offer consultation and support to residential staff. 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. However, at the same time, opportunities again 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. In addition, a number of protections related to ensuring individuals were safe and restraint was properly used were still in need of improvement. For example, physicians were not routinely documenting a schedule for monitoring medical restraint, information about what happened before the restraint often was not adequate, and nursing staff were not properly assessing individuals that had been restrained. The Facility has accomplished a number of the obligations that can lead to compliance with the Settlement Agreement. However, the most difficult challenge remained. Individual Support Plans must be designed and implemented so that more restrictive interventions can be replaced with more individualized and socially integrated opportunities to learn and practice acceptable behavior.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Department of Justice has indicated an interest in certain statistics. In response to this request, the Monitoring Team has included some such numbers in this report, such as the following information related to numbers of restraints. The Monitoring Team is not in a position to verify these numbers, or provide in-depth analysis of these numbers. Clearly, it is the Facility's responsibility to conduct such analyses, and as these analyses have been made available to the Monitoring Team, they are discussed as appropriate with regard to the sections of the Settlement Agreement to which they apply. The following numbers are provided for informational purposes only, and are based on data available from the Facility at the time of the review.

The extent of restraint use was documented in the LBSSLC Behavioral Restraint Reports for 2/12 through 7/12. However, all of this data was not comparable, because of a shift in how restraints were categorized. This is described in further detail below. According to the reports for 2/12 through 5/12, the restraint use included:

<table><tr><th>Type of restraint</th><th>10/1/11 to 2/10/12</th><th>2/1/12 to 5/31/12</th></tr><tr><td>Crisis intervention</td><td>38*</td><td>17</td></tr><tr><td>Emergency personal</td><td>39</td><td>72</td></tr></table>
*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, or now their Crisis Intervention Restraint Plan.

In 6/12, the method for categorizing the type of restraints changed to a listing of physical, mechanical, or chemical. Aggregate data was provided only for 6/12. During that period, there were 25 physical restraints, zero mechanical restraints, and four chemical restraints. The Facility provided no aggregate restraint data for July 2012. Although the Monitoring Team requested summary reports, only individual episodes of restraint were listed for July 2012.

In the Restraint Reports dated 2/12 through 5/12, there were a total of 89 physical restraint episodes documented for twenty-five individuals. The majority of restraints were documented for Individual #124 (13), Individual 288 (12), Individual #320 (12), Individual #31 (nine) and Individual #61 (eight). There was no use of mechanical restraint.

The most recent Behavioral Restraint Report, for September and August 2012, was issued and discussed at the Quality Assurance/Quality Improvement Council meeting held during the week of the Monitoring Team's visit. The Report documented 31</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		instances of physical restraint, no mechanical restraint, and a single chemical restraint during September. As described above, a sample, referred to as Sample #C.1, was selected. The four individuals in Sample #C.1 included: Individual 22, Individual #27, Individual #61, and Individual #124. In its comments on the draft report, the State expressed concern about the size of the sample. The State is reminded of the agreement the parties reached during the June 2011 parties' meetings regarding the acceptability of smaller sample sizes when the Facility indicated it was not in compliance with a Section of the Settlement Agreement. The Facility's Self-Assessment indicated noncompliance with most of the subsections of Section C. As a result, the Monitoring Team chose to review a smaller sample as the parties had agreed was appropriate. Based on the December 2012 parties' meetings, the Monitoring Teams will be working with the parties on more definition of sample sizes, which should address the State's concerns. <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. According to information received from the Director of Behavioral Services during the recent site visit, based on restraint documentation reviewed at the Incident Management meetings and as well as review of restraints through video monitoring, there had not been any prone crisis intervention restraints during the past six months. If staff were unable to hold an individual in the proper position during a restraint episode, they were instructed to release the restraint hold. The review of 16 checklists did not reveal any evidence of prone restraint. Based on informal interviews with 10 direct support staff, 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. The restraint records for the episodes in Sample #C.1 were reviewed, including the restraint checklists, face-to-face assessment forms, and debriefing forms. The following	

#	Provision	Assessment of Status	Compliance
		are the results of this review: ▪ In 16 out of 16 records (100%), there was documentation stating that the individual posed an immediate and serious threat to self or to others. ▪ For the 16 restraint episodes (100%) reviewed, there was no specific evidence that restraint was used as a punishment or for the convenience of staff. Of the four individuals reviewed, for three (75%), the records indicated that restraint was not used in the absence of or as an alternative to treatment. That is, information provided on the Restraint Checklist and/or Crisis Intervention Face-to-Face Assessment and Debriefing Form suggested that interventions prescribed within the PBSP and/or Crisis Intervention Restraint Plan were attempted prior to restraint. Examples in which adequate treatment was present included: ▪ The restraint records, dated 8/9/12 (5:42 p.m. and 5:43 p.m.), 8/10/12 (6:00 p.m.), and 8/13/12 (5:05 p.m.) for Individual #27 showed the attempted use of various strategies outlined in the Crisis Intervention Plan as well as the PBSP to avoid the use of restraint. More specifically, staff attempted multiple interventions to avoid restraint in response to aggression toward staff and peers and, on one occasion, self-injurious behavior. According to recorded checkmarks on the Restraint Checklist, "prompted replacement behaviors," "changed environment," "followed steps in the PBSP," "PMAB communication skills," and "PMAB protection skills" were strategies typically employed in an attempt to avoid restraint. Written descriptions on the restraint checklist as well as the debriefing checklist across selected restraints appeared to support the utilization of these less restrictive strategies prior to restraint. For example, descriptions indicated that staff attempted to change the environment (restraint dated 8/9/12), block and verbally redirect the behavior (restraint dated 8/10/12), and prompted communication as well as step in between and separate Individual #27 from peers (restraint dated 8/13/12). ▪ The restraint records, dated 7/10/12 (5:16 p.m.), 7/12/12 (5:10 p.m.), 7/24/12 (9:56 p.m.), and 7/26/12 (3:54 p.m.) for Individual #61 indicated the attempted use of various strategies outlined in the Crisis Intervention Plan as well as the PBSP to avoid the use of restraint. More specifically, staff attempted multiple interventions to avoid restraint in response to aggression toward staff and on one occasion aggression toward a peer. According to recorded checkmarks on the Restraint Checklist, "prompted replacement behaviors," "changed environment," "followed steps in the PBSP," "PMAB communication skills," and "PMAB protection skills" were strategies typically employed in an attempt to avoid restraint. Written descriptions on the restraint checklist as well as the debriefing checklist across selected restraints appeared to support the utilization of these less restrictive strategies prior to restraint. For example, descriptions indicated that staff attempted to change the environment (restraints dated	

#	Provision	Assessment of Status	Compliance
		7/10/12, 7/12/12, and 7/26/12), verbally redirect the behavior (restraint dated 7/12/12, 7/24/12, and 7/26/12), prompted choice making (7/12/12) and communication (7/24/12 and 7/26/12), as well as positioning themselves between Individual #61 and other peers (dated 7/26/12). ▪ The restraint records, dated 8/6/12 (12:55 p.m. and 1:50 p.m.), 8/9/12 (11:29 a.m.), and 8/13/12 (2:09 p.m.) for Individual #124 indicated the attempted use of various strategies outlined in the Crisis Intervention Plan as well as the PBSP to avoid the use of restraint. More specifically, staff attempted multiple interventions to avoid restraint in response to aggression toward staff as well as an attempt to run out into traffic. According to recorded checkmarks on the Restraint Checklist, "prompted replacement behaviors," "changed environment," "followed steps in the PBSP," "PMAB communication skills," and "PMAB protection skills" were strategies typically employed in an attempt to avoid restraint. Written descriptions on the restraint checklist as well as the debriefing checklist across selected restraints appeared to support the utilization of these less restrictive strategies prior to restraint. For example, descriptions indicated that staff attempted to verbally redirect the behavior (restraints dated 8/6/12 and 8/9/12), and prompted communication (8/6/12) and to calm (8/6/12 and 8/9/12). Although several items (checked items describing "attempts to avoid restraint") were endorsed, written descriptions of de-escalation techniques were not provided as directed (i.e., item 4.1 on the debriefing form). Examples in which inadequate treatment was present included: ▪ The restraint record, dated 5/4/12 (5:05 p.m.) for Individual #22 indicated that staff attempted interventions in his PBSP (i.e., check mark for "interventions in PBSP"). However, his interim PBSP was not implemented until 5/14/12. And, although his PBSP was implemented later that month (on 5/14/12), subsequent restraint records, dated 5/15/12 (2:09 p.m.), 5/27/12 (6:53 p.m.), and 5/31/12 (8:13 p.m.), did not indicate (by recorded checkmark) that staff used "interventions in the PBSP." Staff endorsements did indicate that verbal prompts, redirection, and PMAB protection skills were used across these restraints and, in general, these interventions were identified in the PBSP. However, the plan specifically prescribed the use of a single verbal prompt following verbal aggression and appeared to recommend similar limits (in using verbal prompts or verbal explanations) following physical aggression. Unfortunately, one restraint report (5/27/12) indicated using "verbal prompts" and explanations following aggression to a peer. In addition, none of the restraint records indicated using other interventions found in the PBSP (e.g., moving others away, offering him the chance to change environments). Overall, the lack of information and specification found across restraint records (e.g.,	

#	Provision	Assessment of Status	Compliance
		restraint record dated 5/31/12 did not include any written explanation of attempted interventions to avoid restraint) led the Monitoring Team to question whether or not staff actually attempted strategies prescribed in the PBSP to avoid restraint. Indeed, descriptions listed on one restraint checklist (on 5/27/12) gave the impression that the aggressive incident was over ("… threw a CD at [peer]…") leaving the Monitoring Team to wonder why a basket hold was necessary. Further explanation would have helped prevent the appearance that this restraint procedure might have been used improperly (e.g., primarily as a non-prescribed punishment strategy). Of not, it was unclear if the PBSP for Individual #22 was actually implemented at the time of the identified restraints. The Monitoring Team assumed that the PBSP was in place (for three of the four identified restraints) based on information listed on the header of the first page of the PBSP that indicated "Date Implemented: 5/14/12." Further review of provided documentation, Individual Support Plan Addendum (ISPA) dated 6/5/12, however, indicated that "[Individual #22] does not have a PBSP at this time" and that "… [psychologist] has prepared an interim PBSP that is awaiting consent." As noted above and in the Monitoring Team's previous reports, 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. However, the written descriptions appeared somewhat improved since the last review. This might be due to the use of a revised Crisis Intervention Face-to-Face Assessment and Debriefing Form, now conducted and completed by a psychologist, which required descriptions of de-escalation techniques. One way to improve this rubric would be to have psychologists attempt to estimate the implementation integrity of both the PBSP and the Crisis Intervention Restraint Plan once the staff and individual interview have been completed. Currently, psychologists were only asked to judge whether or not the PBSP was implemented correctly. One continued finding, consistent with the Monitoring Team's previous reports, was the lack of information noting whether or not the staff member(s) involved in the restraint were trained on the individuals' PBSP, crisis intervention restraint plan, and/or PMAB communication and protection skills. Examination of the current restraint reports listed above evidenced that this information was present in none (0%) of documents reviewed. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment. As noted above, staff did not, in some cases, adequately implement strategies prescribed within Behavior Support Plans to potentially prevent the need for restraint. Consequently, the Facility remained out of compliance with this provision.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The use of Safety Plans was discontinued on 5/7/12 as part of the phasing in of the revised State Office restraint policy and procedures. Crisis Intervention Restraint Plans had been implemented for six individuals as of 8/24/12. These individuals included: Individual #27, Individual #57, Individual #61, Individual #124, Individual #240 and Individual #288. A Crisis Intervention Restraint Plan was defined as "a component of the ISP action plan that provides instructions for staff on how to effectively and safely use restraint procedures, as long as they are needed to prevent imminent physical harm in a behavioral crisis when less restrictive prevention/de-escalation procedures have failed and the individual's behavior continues." A review of restraint checklists documented: ▪ In five out of 16 episodes, restraint ended when the staff member was unable to sustain the restraint hold. ▪ In addition, the other episodes reviewed in Sample #C.1 were of brief duration, lasting from less than a minute to eight minutes. In the 11 other restraint records reviewed (100%), sufficient documentation was included to show that the individual was released when no longer a danger to self or to others. The Facility remained in substantial compliance with this provision.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on:	On 7/12/12, the State issued a revised policy entitled "Limitation of Restraint," governing the use of restraint. This policy defined approved restraints and required that staff use only such approved interventions. Direct support professional and clinical staff were trained on this new policy in May and June 2012. At the time of the Monitoring Team's visit, the Facility policy had not been updated yet. Staff were trained on the revised State policy only. The above policy continued to mandate competency-based training for each staff person whose work responsibilities involved direct contact with individuals. This training must be completed before beginning work with any individuals, and it must be repeated annually as a refresher course. 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Documentation the Facility submitted showed 100% compliance with PMAB training requirements. This finding compared favorably with past results. For Sample #C.2, the Monitoring Team requested the following documentation for a sample of 35 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. Review of documentation indicated compliance for 100% of the sample. Based on discussions with 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 remained 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 individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 16 restraint records (Sample #C.1), in 16 out of 16 (100%) there was evidence documented that restraint was used as a crisis intervention. A sample of 14 PBSPs were selected and reviewed to examine whether or not restraints were used for anything other than crisis intervention. This sample reflected approximately 10% of the total number of PBSPs currently in place (N=136, as of 10/4/12). Of the 14 PBSPs reviewed, 14 (100%) showed no evidence that restraint was being used for anything other than crisis intervention. That is, 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 other than crisis intervention. In 16 out of 16 of restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. None of the individuals included in the sample were included on the Do Not Restrain list. As presented subsequently with regard to Section K.4 of the Settlement Agreement, it was noted during the Monitoring Team's current visit that the Facility no longer supported the development and implementation of Safety Plans for Crisis Intervention (SPCI). IDTs were now directed to facilitate the development, implementation, and monitoring of Crisis Intervention Restraint Plans as part of the ISP. That is, these plans were now integrated within the ISP in the form of ISP action plans. This change in LBSSLC restraint policy was completed to ensure consistency with State Office policy. The quality of these plans is discussed with regard to Section K.4 in relation to the	Noncompliance

#	Provision	Assessment of Status	Compliance
		examination of related ongoing monitoring of restraint. An additional change that was noted during the Monitoring Team's most recent visit was the decision by the Facility and State Office to conceptualize use of abdominal binders, in some cases, as protective mechanical restraints for use to prevent self-injurious behavior. This change in LBSSLC restraint policy (revised policy dated 7/12/12) was completed to ensure consistency with State Office policy. The current policy with regard to the use of protective mechanical restraints appeared very comprehensive and included the following requirements: 1) an ISP action plan; 2) completion of a Structural and Functional Assessment Report (SFAR); 3) development and implementation of a PBSP with strategies aimed to strengthen alternative responses and weaken self-injury; 4) consideration by the IDT of the development and implementation of other clinical plans (e.g., habilitation plans) to reduce the need for protective mechanical restraint; 5) procedures for applying the protective mechanical restraint as well as procedures (including a schedule) to fade the use of the restraint; 6) review and approval by a PCP; and 7) a system for daily and monthly monitoring of the use of the protective mechanical restraint by the IDT. Although the change in policy as described above was relatively recent, an attempt to estimate adherence to the above requirements was made by examining a sample of two individuals with abdominal binders currently in place, including Individual #6 and Individual #321. Based on a listing of individuals with abdominal binders, dated 10/4/12, this sample reflected 15% of the total (N=13) number of individuals with binders currently viewed as protective mechanical restraints. Documentation reviewed included the most recent ISP, ISPAs, and ISP action plans, as available, for each individual sampled. In addition the behavioral services tracking grid, dated 10/4/12, was examined. It should be noted the scope of the current review was limited by the omission of the Monitoring Team in not requesting current PBSPs and SFARs as well as ongoing daily and monthly data collection. Based on review of the above documents for Individual #6 and Individual #321: ▪ One (50%) listed the use of the abdominal binder in the ISP as a restraint; ▪ Two (100%) had ISPAs completed since the Monitoring Team's last visit reflecting review of the abdominal binder as a form of restraint by the IDT; ▪ One (50%) had a current ISP Action Plan in place addressing the use of the abdominal binder as a restraint; ▪ Zero (0%) had specific instructions regarding the removal of the abdominal binder (i.e., conditions under which it could be safely removed); ▪ Zero (0%) had a current SFAR in place; ▪ One (50%) had a current PBSP in place; ▪ One (50%) appeared to have alternative clinical or habilitative plans in place to	

#	Provision	Assessment of Status	Compliance
		reduce the need for the restraint; and ▪ Zero (0%) had specific strategies in place to attempt to fade the use of the restraint. Based on review of the documents described above, the following concerns were noted: ▪ The IDT for Individual #6 met on 6/27/12, and at that time, indicated that a revised SFAR would be completed within the next 30 days. Once completed, the IDT planned to reconvene to discuss any implications. According to available documentation, the SFAR was not updated (the most current SFAR date was 8/1/11 as listed on behavioral services tracking sheet), and the IDT did not appear to have reconvened (subsequent ISPAs were not provided for review). In addition, although general information was presented that illustrated the scheduled use of the binder (i.e., "[Individual #6] should wear his Restraint/binder 12p-12a for 50 minutes on and 10 minutes off and not worn during bathing" as stated in ISPA dated 6/27/12), more specific directions regarding the nature of its use (or non-use) were not found. For example, directions were not provided detailing the settings or circumstances under which the binder would be removed each hour and no information was provided on plans to attempt to fade the use of the restraint. Indeed, the schedule of use was further unclear as other available documentation (i.e., ISP Action Plan dated 6/27/12) indicated that the binder would be "applied 12p-12a except during bathing." ▪ The ISP, dated 8/7/12, for Individual #321 did not appear to directly endorse or discuss the use of the abdominal binder as a protective mechanical restraint to prevent the removal of a gastrostomy tube (G-tube). More specifically, although there was one sentence (under "Personal Health Concerns" on page 6 of the ISP, dated 8/7/12) that referenced the abdominal binder (i.e., "04/05/2011 - [Individual #321] was treated for g-tube dislodgment and was reinserted by nursing at the Lubbock State Living Center and ordered an abdominal binder"), there was no other reference to the need or the use of the binder in the ISP. This included its omission under sections entitled "Integrated Risk Discussion" and "Summary of Restrictive Practices." In addition, descriptions of (or directions for) the use of the binder were not included in any of the action plans listed within the ISP. The use of the binder as a restraint, however, was evident in the ISPA, dated 9/21/12. Although the IDT appeared to generally discuss the utilization of the binder, the team did not appear to identify any specific directions about its use other than to indicate that it "… should be worn at all times." Information regarding times when it would be removed or efforts directed at trying to fade its use were not discussed. In addition, there was no evidence that a PBSP or other clinical or habilitative strategies were in place to try to weaken responses prompting restraint or to strengthen alternative	

#	Provision	Assessment of Status	Compliance
		responding. It appeared that the IDT discussed the need for an SFAR and agreed to reconvene once it was completed. That is, as stated in the ISPA: "the behavior analyst reported that this behavior has not been functionally assessed this year and will be completed shortly as his ISP is scheduled to be held during the month of December". It was unclear why the IDT delayed the development and implementation of an Action Plan based solely on the completion of the SFAR, and why reference to a December ISP date was made when the previous ISP was held in August 2012. It should be noted that the conceptualization of an abdominal binder as a protective mechanical restraint (for SIB) was a relatively recent change in the restraint policy. Consequently, adherence to the revised policy might be more robust once IDTs complete ISPs in the future. Indeed, of the thirteen individuals with abdominal binders, only one (8%) had his ISP meeting since the new policy was implemented. As found across the Monitoring Team's previous visits, continual progress had been noted in the area of Dental Desensitization plans. That is, previous observations noted the thoughtful approach of the Facility's Desensitization Committee in identifying individuals who appeared to require more intensive support. The Committee's "desensitization priority list" included individuals determined to have the most need for formalized and more robust desensitization skill acquisition programs (SAPs). Once identified, the individual's IDT was expected to discuss the nature of the skill programming based on the individual's strengths and needs. At the previous Monitoring visit, approximately 32 (29% of those needed) dental desensitization plans and eight (33% of those needed) medical desensitization plans had been completed out of those identified as being needed. At that time, review of the dental desensitization plans revealed that the plans more closely adhered to the revised skill acquisition program format as Psychologists had begun using a self-monitoring checklist to ensure that all the required elements were included. This checklist appeared comprehensive and seemed to include all of the necessary elements of effective SAPs. However, at that time, sampled plans were found to be inadequate as one or more critical elements was either missing or inadequate. In addition, the plans appeared "cookie-cutter" and did not appear to be very individualized. According to summary documentation reported in the Section C Presentation Book, 97 (95%) of 102 dental desensitization plans and 24 (89%) of 27 medical desensitization plans had been completed. In its comments on the draft report, the State indicated that more updated information was handed out at a meeting during the review week. In the future, it will be important for the Facility to add such updated information to the Presentation Book prior to it being given to the Monitoring Team. However, based on a	

#	Provision	Assessment of Status	Compliance
		Monitoring Team member's attendance at the 10/4/12 Meeting of the Desensitization Committee, the spreadsheet prepared for this meeting indicated the Psychology Department, working in conjunction with Dental Services, had identified 101 individuals who could benefit from Skill Acquisition Plans to help them cooperate with dental procedures. It also indicated all of these plans had been developed and were in various stages of implementation. The corresponding number of individuals identified as suitable candidates for pre-treatment sedation for medical procedures was 26, and Skill Acquisition Plans also had been developed for all of these individuals. This reflected progress in the development of needed medical and dental desensitization plans. In addition, current review of a sample plans evidenced adherence to the SAP format as well as continued improvement in quality of plans. Specific feedback regarding the quality of reviewed dental desensitization SAPs are discussed with regard to Section S.1. As presented below and in Section S.1, however, inadequate data collection associated with skill acquisition plans was evident. As discussed with regard to Section Q.2 in relation to dental desensitization, based on information provided in relation to 77 skill acquisition plans that had been available for implementation as of 8/6/12, two months prior to the Monitoring Team's review: ▪ Of the 77 individuals with skill acquisition plans, information (i.e., copies of daily tracking log from the home, copies of tracking log during dental office encounter, monthly log review/reports to determine whether implementation was occurring and a review of results, etc.) was submitted indicating implementation for none of 77 (0%). ▪ Evidence of progress in ability to cooperate for dental procedures through desensitization was submitted in none of 77 (0%). ▪ Evidence of lack of progress in desensitization was submitted in none of 77 (0%). ▪ Evidence of monitoring (monthly analysis) for progress in desensitization was submitted in none of 77 (0%). ▪ Of the 77 individuals with skill acquisition plans developed, information documenting changes/revisions in the skill acquisition plans to adapt to the needs of the individual was submitted in none of 77 (0%). Overall, efforts to improve dental desensitization plans were noted. The quality and individualization of desensitization plans as well as implementation efforts will need to continue to improve for all individuals who are identified as needing this level of support in order for the Facility to be in substantial compliance with this section of the Settlement Agreement.	
C5	Commencing immediately and with	In accordance with the new policy directives, restraint checklists had been revised. Staff	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject 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.	has been trained on both the new policy and the use of the restraint checklists and other forms. Review of training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. Training had been specifically designed and implemented for restraint monitors. A list of 23 trained restraint monitors was included in the documentation received from the Facility. In addition, 21 nurses had been trained to monitor and document the vital signs and mental status during and after a restraint episode. Based on a review of 16 debriefing and assessment forms included in Sample #C.1, a face-to-face assessment was conducted: ▪ In 16 out of 16 incidents of restraint (100%) by an adequately trained staff member. ▪ In 16 out of 16 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The time of notification and the time of the monitor's arrival were required elements on the checklist. In some instances, the monitor was present in the residence when the behavioral episode occurred. ▪ In each of the episodes reviewed (100%), documentation showed that an assessment was completed of the application of the restraint. ▪ The circumstances leading to restraint were to be discussed at both the Unit morning meeting and the daily Incident Management meeting. In 16 out of 16 instances (100 %), the documentation showed that an adequate assessment was completed of the circumstances of the restraint. During the site visit, discussion of recent restraint episodes occurred in both meetings, as expected. In order to ensure that nursing documentation could be adequately reviewed, a separate sample was selected. It was random, except it included only the first restraint if multiple restraints occurred over a short period of time (i.e., one right after the other). In such instances, the initiation of restraint would be counted from the time the first restraint began. Based on a review of this sample of 20 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #124, Individual #27, Individual #288, Individual #61, Individual #31, Individual #2, Individual #36, Individual #143, Individual #240, Individual #57, Individual #213, Individual #60, and Individual #284), there was documentation that a licensed health care professional: ▪ Initiated monitoring at least every 30 minutes from the initiation of the restraint in 13 (65%) of the instances of restraint. Records that did not contain documentation of this included those for: Individual #288; Individual #31, on 5/30/12 and 7/24/12; Individual #143; Individual #240; Individual #57; and Individual #60. ▪ Monitored and documented vital signs in 16 (80%) episodes. Records that did	

#	Provision	Assessment of Status	Compliance
		not contain appropriate documentation of this included those for: Individual #124, on 8/13/12; Individual #2, on 7/31/12; Individual #240, on 6/9/12; and Individual #60, on 7/21/12. 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, and did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ Monitored and documented mental status in six (30%) episodes. Records that did not contain appropriate documentation of this included: Individual #124, on 7/16/12, and 8/13/12; Individual #27, on 7/17/12, and 8/10/12; Individual #288, on 6/9/12; Individual #61, on 8/2/12; Individual #31, on 4/26/12, and 7/24/12; Individual #2, on 7/31/12, and 8/1/12; Individual #36, on 7/11/12; Individual #240, on 6/9/12; Individual #213, on 8/9/12; and Individual #60, on 7/21/12. Problematic issues noted that resulted in noncompliance included either the mental statuses were not recorded, or were generic, such as "alert, and oriented" without a specific description of the behavior included to support the generic documentation. From discussions with the Chief Nurse Executive (CNE) and the Quality Assurance (QA) Nurses, since the last review, the Facility had taken a positive step forward by designating the QA Nurse as responsible for auditing the nursing components of the restraint documentation. However, the Chief Nurse Executive reported that the Nursing Department had not yet established system to review and analyze these data, or to address the problematic issues found related to the data above or the data related to Section C.6, which addressed the documentation of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. Documentation was provided for the two individuals in the sample. There were three restraint episodes for these two individuals. ▪ In zero out of three (0%), the physician specified the schedule of monitoring required; ▪ In zero out of three (0%), the physician specified the type of monitoring required; and ▪ Because schedules were not defined, it could not be determined if adequate monitoring was completed.	

#	Provision	Assessment of Status	Compliance
		Since physicians were not routinely documenting a schedule for monitoring, assessments of the circumstances of restraint were not adequate, and nursing staff were not properly assessing individuals that had been restrained, the Facility remained out of compliance with this provision.	
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.	It is important to emphasize that adherence to the requirements of this provision had been a priority at LBSSLC. Careful review and analysis of the restraint checklist information had formed the basis for the monthly "Compliance Report from Review of Restraint Documents" prepared by the Director of Behavioral Services. His Report tracked compliance with each of the requirements listed below for each restraint episode at LBSSLC. A total of 202 restraints had been examined for the period 2/12 though 8/12. A sample (Sample #C.1.) of 16 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 100%, information about what happened before, including prior to the change in the behavior that led to the use of restraint. The quality of this description was not consistent and, in only two of 16 episodes (13%), did the documentation adequately describe the environmental context, including the presence and actions of peers. The focus was primarily on describing the behavior of the individual, especially his behavior towards staff. Descriptions documented in two episodes involving Individual # 27 (on 8/10/12 at 6:00 p.m. and 8/13/12 at 5:05 p.m.) were consistent with the instruction to "describe the individual's environment, actions, and interactions with others in the time before you began taking steps to avoid the use of restraint." ▪ In 16 out of 16 episodes (100%), the actions taken by staff prior to the use of restraint, in order to permit adequate review, per Section C.8 of the Settlement Agreement, were included on the form. However, the checklist did not require the actions to be described in any detail. It simply required a check against a list of possible actions. It would be helpful to have further information in order to determine whether the PBSP, for example, actually was implemented as written and approved. ▪ In 100%, the specific reasons for the use of the restraint were stated; ▪ In 100%, the method and type (e.g., medical, dental, crisis intervention) of restraint was identified. ▪ In 100%, the names and signatures of staff involved in the restraint episode were listed. ▪ Observations of the individual and actions taken by staff while the individual was	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 was noted in the requisite column. Most often, the codes described the action taken regarding release from restraint. Opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bedpan were seldom recorded. However, this likely was related to the brief duration of the restraints. o 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 were documented. Based on a review of 20 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #124, Individual #27, Individual #288, Individual #61, Individual #31, Individual #2, Individual #36, Individual #143, Individual #240, Individual #57, Individual #213, Individual #60, and Individual #284): ▪ In 13 (65%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. Records that did not contain documentation of this included: Individual #124, on 8/13/12; Individual #61, on 8/2/12; Individual #2, on 7/13/12, and 8/1/12; Individual #36, on 7/11/12; Individual #143, on 7/31/12; and Individual #60, on 7/21/12. Problematic issues noted that resulted in noncompliance included either the injury section being left blank, or the lack of appropriate nursing documentation regarding the specific descriptions of injuries. As noted with regard to Section C.5, because schedules for monitoring of individuals for whom medical restraint was used were not defined, it could not be determined if adequate monitoring was completed.	
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:		

#	Provision	Assessment of Status	Compliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to documentation identifying individuals restrained between 2/1/12 and 8/15/12, at least nine individuals were placed in restraint more than three times in any rolling 30-day period. Of these nine individuals, a sample of four individuals (reflecting a sample of 44%), with more than three restraints in any rolling 30-day period since the Monitoring Team's last visit, was selected for review to determine if the requirements of the Settlement Agreement were met. For each individual selected, four restraints that occurred within a 30-day rolling period were selected (identified individuals as well as specific dates and times are detailed below): ▪ Individual #22 on 5/4/12 (at 5:05 p.m.), on 5/15/12 (at 2:09 p.m.), on 5/27/12 (at 6:53 p.m.), and on 5/31/12 (at 8:13 p.m.); ▪ Individual #27 on 8/9/12 (at 5:42 p.m. and 5:43 p.m.), on 8/10/12 (at 6:00 p.m.) and 8/13/12 (at 5:05 p.m.); ▪ Individual #61 on 7/10/12 (at 5:16 p.m.), on 7/12/12 (at 5:10 p.m.), on 7/24/12 (at 9:56 a.m.), and on 7/26/12 (at 3:54 p.m.); and, ▪ Individual #124 on 8/6/12 (at 12:55 p.m. and 1:50 p.m.), on 8/9/12 (at 11:29 a.m.), and on 8/13/12 (at 2:09 p.m.). Documentation requested for review included Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, Crisis Intervention Restraint Plans, Positive Behavior Support Plans (PBSP), Individual Support Plans (ISPs), ISP Addendums, and Monthly Behavioral Services Reviews. It should be noted that the PBSP and Crisis Intervention Restraint Plan 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. Of the four individuals sampled, three of the individuals' teams (75%) met to discuss the more than three restraints specifically identified above. The following are three instances where teams met to discuss the restraints as identified: ▪ An Individual Support Plan Addendum dated 6/5/12, indicated that the IDT for Individual #22 met and discussed the four restraints that occurred on 5/4/12, 5/15/12, 5/27/12, and 5/31/12. The ISPA template designed to be utilized following more than three restraints in any rolling 30-day period to facilitate adequate team review appeared to be completed. ▪ An ISPA, dated 8/7/12, indicated that the IDT for Individual #61 met and discussed the four restraints that occurred on 7/10/12, 7/12/12, 7/24/12, and 7/26/12. The ISPA template designed to be utilized following more than three restraints in any rolling 30-day period to facilitate adequate team review appeared to be completed. ▪ An ISPA, dated 8/14/12, indicated that the IDT for Individual #124 met and discussed the four restraints that occurred on 8/6/12 (two restraints on that day), 8/9/12, and 8/13/12. The ISPA template designed to be utilized following	Noncompliance

#	Provision	Assessment of Status	Compliance
		more than three restraints in any rolling 30-day period to facilitate adequate team review appeared to be completed. The following is an example where the team failed to meet to discuss the specific restraints as identified: ▪ The IDT for Individual #27 did not appear to meet following the more than three restraints specifically identified above. That is, an ISPA was not provided as evidence that the IDT discussed the four restraints that occurred between 8/9/12 and 8/13/12. However, according to documentation provided (ISPAs dated 7/16/12 and 8/8/12), the IDT met on 7/16/12 to discuss the five restraints that occurred between 7/3/12 and 7/11/12 as well as met on 8/8/12 to discuss the approximate 16 restraints that occurred between 7/17/12 and 8/3/12. In summary, although the IDT met twice to discuss the multiple restraints that occurred throughout July and early August, documentation was not provided that evidenced a third ISPA meeting to discuss the restraints that subsequently occurred in mid July. Consequently, the Facility did not adhere to the criterion as specifically stated in the Settlement Agreement regarding the review of more than three restraints in any rolling 30-day period and, consequently, was not in compliance in this case. It should be noted that the Monitoring Team recognizes ongoing efforts by the State Office to examine how Facilities might best adhere to this requirement, and make proposals to the parties and the three Monitors. Based on the above findings, the subsequent review included the examination of only those ISPAs completed on restraints utilized on selected dates of those sampled, including Individual #22, Individual #61, and Individual #124, as discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Because the team did not meet for Individual #27, this was counted as noncompliance for each of the subsections. However, in an attempt to provide the Facility feedback, review of the PBSP and Crisis Intervention Restraint Plan for Individual #27, as provided, was included when applicable (i.e., Section C.7.e through C.7.g). Of the four individuals reviewed, two (50%) of the individuals' teams adequately reviewed the individual's adaptive skills. The following are examples of where teams adequately reviewed the individual's adaptive skills: ▪ An ISPA, dated 6/5/12, for Individual #22 evidenced that the IDT generally discussed his communication and social skills. In addition, they discussed potential strategies to address better orientation to time and his schedule. It should be noted that the PBSP in place at the time was an interim plan and had not yet identified a replacement behavior. Discussion included the completion of a current structural and functional assessment as well as other strategies to	

#	Provision	Assessment of Status	Compliance
		assist with skill acquisition. ▪ An ISPA, dated 8/14/12, for Individual #124 indicated that the IDT discussed his adaptive skills, including his communication skills, as well as reviewed behavioral data targeting his progress on skill acquisition programming. The following are examples of where teams failed to do this adequately: ▪ ISPA documentation, dated 8/7/12, for Individual #61 evidenced that the IDT determined that his replacement behavior was "… appropriate and successful at redirecting behaviors." However, it was unclear what data this judgment was based upon as his Monthly PBSP Progress Note did not reflect consistent use of any of the three replacement behaviors. In addition, the IDT did not appear to actively discuss the role of these replacement behaviors in promoting or ameliorating the responses that led to his restraint. Indeed, no data appeared to be presented or discussed. ▪ Individual #27's team did not meet. Of the four individuals reviewed, two (50%) of the individuals' teams adequately reviewed the biological/medical factors in a timely manner. The following are examples of where teams adequately reviewed the individual's biological/medical factors: ▪ The ISPA, dated 6/5/12, for Individual #22 evidenced that the IDT discussed biological and medical factors that could contribute to behaviors that led to restraint. For example, his psychiatric and intellectual diagnoses were discussed as well as his seizure disorder. Discussion included following through on additional assessment by his neurologist. ▪ The ISPA, dated 8/7/12, for Individual #61 evidenced that the IDT discussed the role of biological and/or medical factors in contributing to behaviors that led to restraint. The IDT concluded that, although a psychiatric diagnosis was identified, no significant biological risk factor was identified. The following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 8/14/12, for Individual #124 stated that an underlying psychiatric diagnosis was the only biological/medial factor that could have increased the likelihood of the behaviors that led to restraint. However, one of the restraints clearly indicated that he was complaining of pain in his foot and that he became aggressive after being asked to walk back to work. It is unclear why the IDT did not view this as a potential medical factor that might have potentially been related to his unsafe behavior. ▪ Individual #27's team did not meet. Of the four individuals reviewed, three (75%) of the individuals' teams adequately reviewed the psychosocial factors in a timely manner. The following are examples of	

#	Provision	Assessment of Status	Compliance
		where teams adequately reviewed the individual's psychosocial factors: ▪ The ISPA, dated 6/5/12, for Individual #22 evidenced that the IDT discussed potential psychosocial factors that could contribute to behaviors that led to restraint. For example, the team discussed his past social and family history and current influence of and implications for family contact and visits. ▪ The ISPA, dated 8/7/12, for Individual #61 evidenced that the IDT discussed potential psychosocial factors that may have contributed to behaviors that led to restraint. For example, the team discussed his past incarceration, and the likelihood that he was significantly affected by changes in the population of his home and the behaviors exhibited by his peers. ▪ The ISPA, dated 8/14/12, for Individual #124 indicated that the IDT reviewed his past history of abuse, as well as the potential influence of recent contact with family members who might have suggested reconnection with a parent who might have abused him. The IDT reported that contact with family members was monitored.	
	(b) review possibly contributing environmental conditions;	Of the four individuals reviewed, two (50%) of the individuals' teams reviewed the potential contributing environmental conditions. The following are examples of where teams adequately reviewed potentially contributing environmental conditions: • The ISPA, dated 6/5/12, for Individual #22 evidenced that the IDT discussed potential environmental factors that could have contributed to behaviors that led to restraint. For example, the team examined potential environmental conditions, including changes in the living situation, peers, routines, and schedule. The team appeared to focus on his desire to access his and other's personal possessions. • The ISPA, dated 8/7/12, for Individual #61 evidenced that the IDT discussed potential environmental factors that might have contributed to behaviors that led to restraint. For example, the IDT hypothesized that changes in the population of the home had led to less time for Individual #61 with regard to his interaction with preferred staff. The following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 8/14/12, for Individual #124 clearly indicated that several of the restraints were in response to unsafe behavior that resulted from his inability to find an item that belonged to him. It was unclear why the inability to locate this item was not considered a potential environmental factor that was related to the behavior that led to restraint. ▪ Individual #27's team did not meet.	Noncompliance
	(c) review or perform structural	Of the four individuals reviewed, three (75%) of the individuals' teams adequately	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessments of the behavior provoking restraints;	reviewed or performed structural assessments of the behavior provoking restraints. The following are examples of where teams adequately reviewed or performed structural assessments of the behavior provoking restraints: ▪ The ISPA, dated 6/5/12, for Individual #22 evidenced that the IDT examined each restraint, attempted to identify precursors of each restraint and common elements, and discussed the upcoming completion of the structural and functional assessment. The team appeared to consider potential functions underlying the target behaviors. ▪ The ISPA, dated 8/7/12, for Individual #61 indicated that: "the IDT reviewed the behaviors that resulted in restraint and what happened before the behaviors." In addition, it appeared that the IDT discussed the recently completed SFAR and Crisis Intervention Restraint Plan. The Team indicated that: "no new information or observations have indicated a change in the functions of behavior." ▪ The ISPA, dated 8/14/12, for Individual #124 indicated that the IDT reviewed the behaviors that led to the restraints and found the conditions consistent with the current SFAR, dated 1/5/12, and determined that additional assessment was not warranted at that time. The team indicated that the potential functions of target behaviors were consistent with those previously identified in the SFAR. As noted above, Individual #27's team did not meet.	
	(d) review or perform functional assessments of the behavior provoking restraints;	This is discussed above with regard to Section C.7.c.	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	Of the four individuals reviewed, three (75%) individuals had a current PBSP at the time of the restraints. The exception was the PBSP for Individual #22. Although an interim PBSP appeared to have been written, it was currently unclear if it was actually implemented at the time of the selected restraints. The Monitoring Team had initially assumed that the PBSP was implemented on 6/5/12 and, as a result, believed it to be in place when three out of the four identified restraints were utilized. This assumption was based on information conspicuously displayed on the PBSP that indicated: "Date Implemented: 5/14/12." However, examination of the ISPA, dated 6/5/12, revealed IDT discussion stating that: "[Individual #22] does not have a PBSP at this time" and that "[psychologist] has prepared an interim PBSP that is awaiting consent." Consequently, the Monitoring Team surmised that the interim PBSP was written, but not yet in place at the time of the identified restraints. However, to facilitate a more comprehensive review, the PBSP for Individual #22 was included in the following review. Of the four individuals in the sample who had PBSPs, the following was found based on a	Noncompliance

#	Provision	Assessment of Status	Compliance
	authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	review of these PBSPs: ▪ One (25%) appeared based on the individual's strengths. o The exceptions were the PBSPs for Individual #27, Individual #61, and Individual #124 that did not conspicuously identify strategies as based on specific individual strengths. ▪ Three (75%) specified the objectively defined behavior to be treated that led to the use of the restraints. o The exception was the PBSP (revised implementation date of 7/25/11) for Individual #61 that did not identify or define physical aggression. ▪ Two (50%) specified alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint. o The exceptions were the PBSP for Individual #22 that did not include any replacement or adaptive behaviors and the PBSP for Individual #27 that only identified the use of a "picture schedule." This appeared to be an inadequate adaptive response and/or replacement behavior to his significant aggression directed at peers and staff. ▪ Four (100%) specified, as appropriate, the use of other programs (preventative and/or consequence based strategies) to reduce or eliminate the use of such restraint. Of the four individuals reviewed, three (75%) individuals had a Crisis Intervention Restraint Plan in place at the time of the selected restraints. The one exception was Individual #22. The ISPA, dated 6/5/12, indicated the IDT actively discussed the need for a Crisis Plan and determined that it was "too early to determine whether a crisis intervention is necessary." The following results are based on the review of the three Crisis Intervention Restraint Plans: ▪ In three (100%), the type of restraint authorized was delineated; ▪ In three (100%), the maximum duration of restraint authorized was specified; ▪ In three (100%), the designated approved restraint situation was specified; and ▪ In three (100%), the criteria for terminating the use of the restraint were specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Of the four individuals reviewed, only one of the individuals' teams adequately reviewed data related to the treatment integrity of the PBSP as evidenced by available ISPAs. Of note, the PBSP for Individual #22 did not appear to be implemented yet. Consequently, treatment integrity data would not have yet been available for discussion by the IDT. This resulted in one out of three teams (33%) appropriately discussing treatment integrity. The following is an example of where a team adequately reviewed treatment integrity data of the PBSP designed to reduce behaviors likely to lead to restraints:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ The ISPA (dated 8/14/12) for Individual #124 indicated that the IDT discussed the implementation integrity of the PBSP as well as inter-observer agreement (IOA) data. More specifically, the ISPA indicated that: "All competency integrity and inter-observer data reflect agreement at 100%." The following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 8/7/12, for Individual #61 did not evidence discussion of treatment integrity data related to the PBSP. ▪ Individual #27's team did not meet.	
	(g) as necessary, assess and revise the PBSP.	Of the four records reviewed, zero (0%) evidenced discussion and revision of the individual's PBSP as necessary. The following are examples of where teams did not discuss, assess, or revise the PBSP, as necessary: ▪ The ISPA, dated 8/7/12, for Individual #61 indicated that the IDT discussed the recently completed SFAR as well as the recently revised and implemented PBSP. However, the lack of an operational definition for physical aggression should have prompted a revision in the PBSP. ▪ The ISPA, dated 8/14/12, for Individual #124 indicated that the IDT discussed the current PBSP, including discussion of its recent review at BSC, as well as information provided by the psychologist regarding upcoming revisions. However, it was not clear that individual strengths were included in the current PBSP or considered within the upcoming revision. ▪ The ISPA, dated 6/5/12, for Individual #22 indicated that the IDT discussed the interim PBSP (that had not been implemented yet), and how included procedures might address underling functions discussed. However, it was unclear if a replacement behavior was discussed and/or included in the revised plan. ▪ Individual #27's team did not meet. 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., SFAR, PBSP, and SPCI).	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review	Current policy required that all restraint data be entered into the database within five working days of the restraint. The Facility was to trend and analyze the data each month. Using the data, the Facility was to evaluate its effectiveness in reducing the use of restraint both in terms of frequency and duration.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	According to the new State Office policy, each restraint used for a person without a crisis intervention plan was to be reviewed within one day by the IDT. With a crisis intervention plan, the schedule could be individually determined. However, according to the Settlement Agreement, a review of the restraint needed to be completed within three business days. As indicated 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. During the onsite monitoring visit, Incident Management Review Team meetings were observed and, during this time, 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. In fact, the restraint checklists examined for Sample #C.1 documented that: ▪ Review and discussion occurred at the Incident Management Review Team meetings within three business days in 16 out of 16 (100%) of the restraint episodes. ▪ The Restraint Monitor completed debriefing forms, as required, in the 16 restraint episodes with debriefing forms provided. ▪ In 16 out of 16 (100%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. ▪ In 16 out of 16 (100%), the review conducted by the Unit IDT and the IMT was sufficient in scope and depth to determine if the application of restraint was justified, if the restraint was applied correctly and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. ▪ For none of four individuals (0%), changes were made to the individuals' ISPs. As discussed with regard to subsection C.7.g, changes should have been made to individuals' ISPs, but were not. ▪ 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. The Facility acknowledged in its Action Plans for Section C.8 that additional work was needed with this provision. The Facility remained out of compliance with this provision, because as discussed above, a key component was missing from the Facility's follow-up to restraint. Specifically, as the Settlement Agreement explicitly requires, ISPs should be	

#	Provision	Assessment of Status	Compliance
		modified as appropriate.	

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. (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 Crisis Intervention Plan. (Section C.1)
5. The Facility should ensure adherence to the new restraint policy with regard to the use of abdominal binders as protective mechanical restraints for self-injury. (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 develop and implement a system to ensure the Nursing Department regularly reviews auditing data regarding restraints, and that plans of correction are implemented addressing the problematic issues identified. (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. This should include highlighting the importance of discussing (and documenting) whether or not identified factors (e.g., adaptive behavior, biological/medical and psychosocial factors, etc.) were related to the current restraints and, if they were, what implications for future programming were considered or acted upon. (Section C.7)
11. The Facility should examine whether or not the "date implemented" as listed on PBSPs accurately reflects the date on which PBSPs are actually implemented. That is, PBSPs should have been finalized, all necessary consents obtained, and training completed prior to recording an implementation date. (Section C.7)
12. 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)
13. 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)
14. 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: ▪ **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 LBSSLC Policy: Incident Management: Observation Note Audit Procedure, dated 6/19/12; o LBSSLC Policy: Campus Coordinator/Administrator Log Procedure, dated 6/19/12; o Sample #D.1 included a sample of 20 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: 41345277, 41520332, 41662574, 41682357, 41697959, 41714033, 41724453, 41856396, 42001813, 42023672, 42110692, 42113092, 42132414, 42141073, 42316834, 42345164, 42381053, 42389854, 42392230, and 42451636; o Sample #D.2 included a sample of 10 investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample #D.2 included cases: 12-121, 12-138, 12-167, 12-176, 12-177, 12-201, 12-224, 12-225, 12-228, and 12-239; o Sample #D.3 included DFPS Investigation 42042812; o Incident Management Review Team (IMRT) meeting minutes for each Monday since the Monitoring Team's last site visit; o Individual Support Plans (ISPs) for Individual #146, Individual #6, Individual #242, and Individual #86; o List of Individuals (one) 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 35 employees; o Training transcripts for 35 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 from 3/21/12 to 7/26/12; o For the last year, lists of injuries by individual, living area, and by type; o Settlement Agreement Compliance reports for Section D, including inter-rater reliability score sheets and Quarterly summaries, dated from 3/12 through 7/31/12; o Trend Analysis Reports for the Executive Safety Committee, dated 10/3/12; o Self-Advocacy Committee Minutes, from 3/21/12 to 8/14/12; and o Minutes of the Human Rights Committee (HRC), from 3/29/12 through 9/12/12.

	▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs; 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 Rodney Meeks, Unit I Director; o Sheila Powell, Human Rights Officer; o Jim Forbes, M.Ed, BCBA, Director of Behavioral Services; o Dawn Ripley, Director of Quality Assurance; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o Site visits to living units and the workshop. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees as well as some of the individuals; o Incident Management Review Team Meetings, on 10/2/12, 10/3/12, and 10/4/12; o Executive Safety Committee meeting, on 10/3/12; o Quality Assurance/Quality Improvement Committee meeting, on 10/3/12; o ISP meeting for Individual #140; o Self-Advocacy Committee meeting, on 10/3/12; and o Unit II morning meeting, on 10/3/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D, dated 8/30/12. In its Self-Assessment, for each subsection, 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. For Section D, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management." In conducting its self-assessment, the Facility selected a sample of investigations from the database of all cases from the previous two months, and applied this tool. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement. o The monitoring tools included some adequate methodologies. For example, the

	investigation case files, training documentation, and rights posters were reviewed. Interviews and observation were to be conducted as appropriate. However, "appropriate" was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist of documentation review alone. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). However, this sample sizes were not adequate to consider them representative samples. A random sample of four investigation files was selected for review each month, irrespective of the number of investigations conducted during the monitoring period. o The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, there was not consistency (inter-rater reliability) on all questions of the tool. The Facility should assess whether the current instructions are adequate, or if other issues (e.g., staff training on the tools) were contributing to the lack of reliability. o The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitors from the Quality Assurance Department worked collaboratively with Department staff to conduct the audits. (Department staff positions were not identified in the documentation reviewed.) o It could not be determined from the information provided whether the staff persons responsible for conducting the audits were competent in the use of the tools, and whether they were clinically/programmatically competent in the relevant area(s). o According to the information provided, adequate inter-rater reliability was reviewed, but had not been consistently established between the various Facility staff responsible for the completion of the tools. This remained a priority issue for the Facility. ▪ Used some relevant data sources and/or key indicators/outcome measures. In addition to data from the audits of investigation files, the Facility also cited some other data in its Self-Assessment. For example, it used data from the Competency and Training Department database on A/N/E training. In addition, the Facility recognized that some data was not yet available, including data from a tracking system for alleged perpetrators. However, the Facility did not present data on key indicators or outcome measures in its Self-Assessment. It was the Monitoring Team's understanding that State Office was working on developing such measures. ▪ The Facility consistently presented some data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Many of the findings were presented as specific, measurable indicators. However, many indicators were missing. Just as one example, Section D.3.e includes a number of requirements related to investigation reports. However, the Facility only addressed two. o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following subsections of Section D*:* Section D.1, Section D.2.c, Section D.2.d, Section D.2.e, Section D.2.f, Section D.2.g, Section D.2.h,

	Section D.3.a, Section D.3.b, Section D.3.c, Section D.3.d, Section D.3.f, Section D.3.g, Section D.3.h, Section D.3.j, Section D.4, and Section D.5. This was not entirely consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with all of the above subsections except the following subsections: Section D.3.f, Section D.3.g, D.3.h, and D.4. The Facility's Self-Assessment did not include all of the components included in these provisions of the Settlement Agreement. ▪ The Facility data did not identify in sufficient detail the areas in need of improvement. There was scant analysis of the information, without identifying, for example, potential causes for the issues leading to the issues or connecting the findings to the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The leadership and staff of LBSSLC are to be strongly commended once again for their unrelenting commitment to zero tolerance of abuse, neglect, and exploitation. This commitment continued to be evident throughout the onsite visit and the extensive review of documentation that followed it. There were repeated examples of disciplinary action, including dismissal, taken against employees who had violated the rights and protections of the individuals under their care. The investigation process itself had been strengthened by the expedited commencement of the investigation, within the first twenty-four hours, and consistent adherence to timeframes for the completion of the investigation reports. The Incident Management Coordinator and his staff had worked diligently to respond promptly and efficiently to the notice of an allegation. In addition, there appeared to be a clear understanding of the investigation protocols, and there was a detailed system for tracking the requisite actions. The review of thirty-one investigation reports found that, in general, both the DFPS and Facility reports were succinct yet thorough. However, some concerns were noted with regard to the basis for the conclusions in Facility investigations. In addition, as cited in past reports, concerns still were noted with regard to DFPS and Facility investigators' review of the previous history of alleged perpetrators and victims. Since the Monitoring Team's last visit, the Incident Management Coordinator had implemented systematic methods for data collection and analysis. In several forums, including the Quality Assurance/Quality Improvement Council, his work was discussed in combination with the analyses of restraint and injuries the Director of Behavioral Services and the Risk Manager compiled. The compilation of this information had begun to contribute to a deeper understanding of the nature of risk at LBSSLC, and the need to design and implement creative, yet practical, solutions to significantly entrenched problems. The development of a database to track and address peer-on-peer aggression was one example of the creative problem-solving underway. As this work evolves, it will be critical that sustainable interventions be secured through staff training, increased activities for habilitation, and improved living environments. The unacceptably high turnover of direct support professionals in the residential areas had complicated these initiatives. However, the Facility's serious attempts to understand and address the causes of staff turnover were noted by the Monitoring Team. Although Section D was not found to be in full compliance with the provisions of the Settlement Agreement, continued progress was recognized. As a result, the Facility's focus on the development and implementation of accurate databases, the analysis of trends by individual and by residential unit, and the identification and

	replication of positive practices that had eliminated some injuries and other serious incidents continued to merit the time and energy of all staff working at LBSSLC.

#	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.	Based on a recent agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. LBSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result the Facility was found to be in compliance with this provision.	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 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	According to the LBSSLC policy "Incident Management: Abuse, Neglect or Exploitation," staff were required to verbally report abuse, neglect, and exploitation immediately or within one hour. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the Facility policy entitled "Incident Management: Managing Unusual Incidents" required staff to report serious incidents immediately or 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. On June 19, 2012, the Facility had issued a policy entitled: "Incident Management: Observation Note Audit Procedure." The purpose of this directive was "to ensure that all events involving the possible under-reporting of incidents or injuries are discovered, reviewed and corrected to prevent future occurrences and provide the safest possible environment for LBSSLC residents." In order to implement this policy, each Campus Coordinator was required to conduct an observation note review each fiscal quarter for every resident on one assigned home. The information gathered during the audit was to	Noncompliance

#	Provision	Assessment of Status	Compliance
	unusual incidents, using standardized reporting.	be entered into a database. The failure to report injuries or incidents was to be addressed by the Incident Management Coordinator and the appropriate Department heads. This protocol already had identified instances of the failure of staff to report as required by policy. The responsibilities of the Campus Coordinators were further delineated in LBSSLC Policy: "Campus Coordinator/Administrator Log Procedure." This policy, dated 6/19/12, required the database entry of all significant events occurring at the Facility. Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note again 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. 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. In addition, he, the Risk Manager and the Director of Behavioral Studies continued to collaborate very closely to document detailed information about the occurrence and co-occurrence of serious incidents, injuries, and the use of restraint. Their analyses had become more sophisticated and focused on trends. Their reports were presented at the Executive Safety Committee and the Quality Assurance/Quality Improvement Council meetings 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. Document Request TX-LB-1210-III.16 provided the numbers for each serious incident category. Despite the specifics of the document request, the data were provided for January 1, 2011 through August 15, 2012. It was not broken down by date or year as requested. As a result, the following information summarized the data provided to the Monitoring Team for the entire period:	

#	Provision	Assessment of Status	Compliance

	1/1/11 to 8/15/12 (19.5 months)
Deaths	12
Serious Injuries	42
Sexual Incidents	13
Suicide Threat (credible)	6
Unauthorized Departure	32
Choking	4
Other (med error, police)	3

A narrower set of figures was presented at the Executive Safety Committee meeting conducted during the site visit. According to the injury report dated October 3, 2012, the following injury counts were identified:

	4/1/12 to 10/1/12
Serious Injuries	9
Non-serious injuries	841

According to documentation reviewed, these injuries had been analyzed by living unit, day of the week, and shift. Scratches accounted for the highest number of non-serious injuries. Increased attention to cause remained an issue of concern to the Facility's leadership. For example, investigation 42141073 focused on the lack of supervision that caused a scratch to the eye of Individual #9.

Documentation provided to the Monitoring Team for the period 1/1/11 through 8/15/12 indicated:

- There were 202 allegations of physical abuse, including 50 that were substantiated (25%), 124 that were unsubstantiated (61%), and 28 that were inconclusive (14%).
- There were 83 allegations of emotional/verbal abuse, including 15 that were substantiated (18%), 59 that were unsubstantiated (71%), and nine that were inconclusive (11%).
- There were 188 allegations of neglect. Of these, 83 were confirmed (44%), 96 were unconfirmed (51%), and nine allegations were inconclusive (5%).
- There were two allegations of exploitation. There was one unsubstantiated allegation (50%) and the other was inconclusive (50%).

Although not directly related to this provision, despite the capacity to do so, since the last site visit, there had been no root cause analyses conducted. However, there were specific actions being implemented for some individuals at higher risk. The individuals'

#	Provision	Assessment of Status	Compliance
		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 aggression among peers, 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. However, efforts to identify and address systemic causes were being initiated but were still at a rudimentary level. Although there was increased attention to the individual, programmatic and environmental factors did not seem to be explored as intensively. These efforts are discussed in more detail with regard to Sections D.3.i and D.4. Based on an interview of 10 direct support staff responsible for the provision of supports to individuals, 10 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Their identification badges outline the specific steps for reporting. 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. Based on an interview of 10 direct support staff responsible for the provision of supports to individuals, 10 (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 20 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: 41345277, 41520332, 41662574, 41682357, 41697959, 41714033, 41724453, 41856396, 42001813, 42023672, 42110692, 42113092, 42132414, 42141073, 42316834, 42345164, 42381053, 42389854, 42392230, 42451636; and ▪ Sample #D.2, which included a sample of 10 investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample #D.2 included cases: 12-121, 12-138, 12-167, 12-176, 12-177, 12-201, 12-224, 12-225, 12-228, and 12-239; In addition to the investigation reports contained in Sample #D.1 and D.2, an additional incident report was selected for review, based on information obtained during the site visit. Sample #D.3 included DFPS investigation 42042812. Based on a review of the 30 investigation reports included in Sample #D.1 and #D.2: ▪ Based on information included in the investigation files, individuals or, at their	

#	Provision	Assessment of Status	Compliance
		request a family member, filed two reports. These incidents of delayed reporting were not included in the percentage cited here, because there was no requirement that individuals or family members report timely. In addition, there were eight investigations in which the time of occurrence was unknown and timeliness, therefore, could not be determined. Therefore, of the applicable investigations reviewed, 10 out of 20 (50%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Investigation reports that documented delays in reporting included: 12-177, 12-201, 12-228, 41856396, 42001813, 42110692, 42113092, 42141073, 42316834, and 42389854. ▪ 30 (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 one investigation report under review by the District Attorney. This investigation concerned the allegation of physical abuse against Individual #115. The allegation was confirmed. The employee was terminated and the District Attorney was pressing charges. ▪ The one investigation 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 incidents. Based on a review of 30 investigation reports included in Sample #D.1 and Sample #D.2, 30 (100%) contained a copy of the report utilizing the required standardized format. Based on the review of the one investigation in Sample #D.3, the requirements for the use of a standardized reporting format also were 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	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 30 investigation reports included in Sample #D.1 and Sample #D.2,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 undisputed policy/practice of LBSSLC to assign alleged perpetrators away from the site of the allegation until the investigation was completed, and they were cleared. Review of 31 investigations documented that re-assignment was handled promptly in every incident. Alleged perpetrators were assigned administrative or foodservice tasks. Since the Monitoring Team's prior visits, the Facility had begun to track the date of return to duty or the final action, if any, taken against the employee. However, this work remained incomplete during the current site visit review. According to information provided by the Facility during an interview with the Incident Management Coordinator, the Incident Management Coordinator was continuing to address the adequacy of the report and to begin the analysis of data to determine whether adequate protections were implemented. Nonetheless, progress was being made with this requirement. It was positive that 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. This document was provided to the Monitoring Team, and was an important step towards achieving compliance with this provision. However, in order to fully protect individuals from harm, it is essential that an adequate and operational mechanism be in place to allow Facility Administration, including the Incident Management Coordinator, to know at any given point in time the status of alleged perpetrators, the completion or findings from investigations, and the status of the employees involved. The progress of this initiative will continue to be reviewed during the Monitoring Team's visits. 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. As noted in the last report, 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	

#	Provision	Assessment of Status	Compliance
		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 substantive 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. ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. The Facility provided documentation for 35 staff selected randomly from the current list of employees. Review of records indicated that these 35 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. One employee had reported an allegation and confirmed that the process worked as expected. All (100%) of these staff could describe reporting procedures accurately. Posters reminding employees of this duty were posted throughout the Facility's buildings. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(d) Notification of all staff when commencing employment and	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	exploitation. The statement was first signed at new employee orientation and, then, annually thereafter. A sample of 35 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 10 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 identified as having failed to timely report abuse and/or neglect. The Facility indicated that two staff were reprimanded or received performance counseling for their failure to report an allegation of abuse. The two employees were cited for the same incident, which occurred on 4/28/12. This illustrated the Facility's commitment to address staff's failure to report incidents. The Facility remained in substantial compliance with this provision.	
	(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. His office maintained a notebook where signed statements were kept. The notebook was examined during the site visit. It appeared complete and was well organized. Based on the Monitoring Team's review of this information, the Facility carefully tracked the provision of this information to individuals' LARs and/or primary correspondents. 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. Since the last site visit, in preparation for the annual ISP meeting, information about an individual's incident, injury, and restraint data had been given to the QDDPs. Investigation reports were now provided to the QDDPs who were then responsible for sharing the information with the team. The obligation to report an incident was to be raised with the individual and the family/guardian at the ISP meeting. Based on the Monitoring Team's observation, the incident and injury information was discussed at the ISP meeting for Individual #140 conducted during the week of the site visit, and information was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		provided to him and his guardian about the reporting process. The review of investigation case files documented that one Individual (42023672) and a family member (41520332) reported allegations of abuse. Each of these reports was investigated. ISPs were examined for Individual #6, Individual #86, Individual #146 and Individual #242. Information about the identification and reporting of incidents and allegations was found in the ISP or ISP Addenda for Individual #6, Individual #86, Individual #146, and Individual #242. The Facility had a process in place to ensure annual provision of information about identification and reporting of incidents through both the mail and the ISP meetings. The Facility's log showed that the Facility was consistently conducting this activity. The Facility was found to be in substantial compliance with this provision.	
	(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 visited during the site visit. During this site visit, the posters were visible and placed at the appropriate eye level. Monitoring of the posters was assigned to the Campus Administrators who had a well-established presence in the residential and program areas. 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, employees stated that their usefulness was very limited. As recommended previously, 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 use of the posters would be supplemented and enhanced by participation in the Self-Advocacy Group. When queried	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		about their knowledge of this Group, some individuals expressed interest but also a lack of knowledge about membership. Expanded outreach might be useful. In addition, a review of the meeting minutes indicated that meetings had been cancelled due to the weather, but not rescheduled. Continuity of opportunities to participate in self-advocacy would help increase membership. The Facility remained in substantial compliance with this provision.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to LBSSLC policy "Incident Management: Abuse, Neglect or Exploitation," immediately or 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 was one investigation currently under review by law enforcement agencies. A finding of physical abuse in investigation 42042812 had led to the District Attorney's decision to bring charges against the employee, who was dismissed from LBSSLC. There also was evidence that the Office of the Inspector General (OIG) was notified appropriately in six DFPS cases. Quarterly meetings were continuing to be convened In order to maintain strong working relationships with the OIG. Meeting agendas were provided to the Monitoring Team. The Facility remained in substantial compliance with this provision.	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	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, one Unit Director, and informal conversations with employees, no staff had reported a fear of retaliation or knew of such fear in another person.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	manner.	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. Based on a review of 31 investigation files (the 30 investigations in Samples D.1 and D.2, plus the one investigation in Sample #D.3), no concerns were noted in relation to potential retaliation. The Facility remained in substantial compliance with this provision.	
	(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 has made progress in implementing the requirements for this provision. As discussed above, periodic review of observation notes for every individual was assigned as a responsibility of the Campus Coordinators/Administrators. Trend data, derived from the database, was to be analyzed and discussed with the Executive Safety Committee in order to develop any necessary Corrective Action Plans. This plan was underway and scheduled for completion by 10/31/12. It was noted during the Executive Safety Committee meeting that patterns of injury types and locations were beginning to be analyzed and referred to the appropriate personnel for further investigation. However, this process was just in the beginning stages. The Monitoring Team will review the Facility's progress in this regard during upcoming reviews. The Facility was not yet in compliance with this provision. In its comments to the draft report, the State requested a reconsideration of the finding of noncompliance. However, although some of the processes described above had begun to be implemented in the months leading up to the most recent review, the Settlement Agreement explicitly requires "at least semi-annual" audits. In addition to showing that this was an established and ongoing process, the Facility also should provide evidence to show that it was resulting in "significant resident injuries" (i.e., including serious injuries as well as significant patterns or types of incidents) being referred for investigation when identified.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year,		

#	Provision	Assessment of Status	Compliance
	the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy Number 002.2: Incident Management, dated 6/18/10, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 012: Protection from Harm - Abuse, Neglect and Exploitation, dated 6/18/10, established procedures for the identification, reporting, trending, analysis of incidents, and prevention of abuse, neglect, and exploitation at State Supported Living Centers. DADS Policy Number 002.2 specified the training required for investigators, and the expectation that they not be in the direct line of supervision of an alleged perpetrator. LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation" described in a detailed manner how investigations would be conducted by the Facility, or referred to DFPS. The policy required that investigators be qualified through training, including completion of specific courses: Comprehensive Investigator Training, People with Mental Retardation, Conducting Serious Incident Investigations or Fundamentals of Investigation, and a class in root cause analysis. The policy also stated that the investigator must not be in the direct line of supervision of the alleged perpetrator. Based on the sample of records reviewed, none of the DFPS or Facility investigators were within the direct line of supervision of the 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. ▪ DFPS provided transcripts regarding the training provided to its eight investigators. According to the information provided, all investigators (100%) had received training in fundamentals of investigations, and in working with	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. However, he had attended the requisite training. A sixth Campus Coordinator had been hired, on 9/16/12, to provide additional Incident Management presence. She has received training in all required courses except one. Her final course was scheduled to begin on 10/16/12. The Facility remained in substantial compliance with this provision.	
	(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. Based on review of Sample #D.1 and Sample #D.2, which consisted of DFPS investigations and Facility investigations, respectively: ▪ All investigations (100%) showed 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. The Facility remained in substantial compliance with this provision.	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, 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 20 investigation records from DFPS (Sample #D.1), there was no indication of direct involvement by the law enforcement agencies. However, notification was made to the OIG in six of the 20 cases. A case file was opened by OIG in investigation 42451636 involving a sexual incident between peers. In addition, OIG was notified of investigation 42023672, but did not participate. For the one out of the one in which law enforcement was involved (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of 10 investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies because of the nature of the incidents (e.g., falls, medication error, injuries of determined cause without suspicion of abuse or neglect, sexual incident between peers, unfounded allegations, etc.). ▪ As indicated above, the District Attorney was prosecuting the perpetrator in investigation 42042812, which was included in Sample #D.3. ▪ Discussion with the investigators and the Incident Management Coordinator indicated a high level of cooperation between the Facility and law enforcement agencies. The Facility remained in substantial compliance with this provision.	
	(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

#	Provision	Assessment of Status	Compliance
		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. The Facility remained in substantial compliance with this provision.	
	(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 20 DFPS investigations: ▪ Nineteen (95%) 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. Such evidence was not found in the documentation provided for investigation 42001813. 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. ▪ Fourteen out of twenty investigations were completed within 10 calendar days of the incident, including sign-off by the supervisor. Extensions were requested for three of the remaining investigations. This resulted in either timely	Noncompliance

#	Provision	Assessment of Status	Compliance
		completion or an appropriate extension for 18 out of 20 (90%). This evidence was not located for 42451636, or 41662574. In its response to the draft report, the State indicated that 42451636 was completed timely, and indicated it was reported on 3/30/12. However, in reviewing documentation again, the Monitoring Team found that the allegation was reported on 3/28/12, and the investigation was begun on that date. The investigation was completed and signed by the supervisor on 4/9/12. No extension request was included in the file. ▪ All investigations (100%) resulted in a written report that included a summary of the investigation findings. ▪ In two of the investigations (10%) reviewed, recommendations for corrective action were included. In these investigations, the recommendations were adequate to address the findings of the investigation. As noted in previous reports, 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 15 out of 30 (50%) 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> Of note, the Facility provided information about the follow-up to any incident in the investigation file itself. This was helpful in ensuring that the follow-up activity could be tracked to conclusion. The following summarizes the results of the review of 10 Facility investigations: ▪ Ten out of ten (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident.	

#	Provision	Assessment of Status	Compliance
		▪ Eight out of ten (80%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. One investigation was referred for peer review (12-138) for which no information was provided to allow determination regarding whether this occurred timely, and the timeliness of one investigation (12-121) was not clear. ▪ All but two investigations (12-121 and 12-177) or (80%) resulted in a written report that included a clear summary of the investigation findings. For case 12-121, an adequate summary was not provided to justify the investigator's finding or show that adequate evidence had been obtained/considered. Similarly, for case 12-177, an adequate summary was not provided to justify the finding or identify factors that could be relevant to preventing recurrence of a similar incident. ▪ In seven of the ten investigations reviewed, relevant recommendations for corrective action were included. Recommendations were not necessary in the remaining cases. ▪ In all of the investigations (100%) in which recommendations were present, the recommendations were adequate to address the findings of the investigation. There was evidence of attention to staff training to prevent similar incidents. The Facility remained out of compliance with this provision. The Facility should continue to address the timely completion of investigation reports. In addition, it is essential that adequate recommendations be developed in relation to DFPS investigations. Investigations are only useful in protecting individuals from harm if they are used to develop and implement an appropriate set of recommendations addressing both personnel and programmatic issues.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person	The 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)	Noncompliance

#	Provision	Assessment of Status	Compliance
	interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	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. More in-depth analysis about previous incidents involving both the victim and the alleged perpetrator, and their relevance, if any to the present investigation would helpful to the adequate formulation of conclusions and the development of recommendations. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In all of the investigations, or 100%, the contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 20 out of 20 (100%), each serious incident or allegations of wrongdoing; o In 20 out of 20 (100%), the name(s) of all witnesses; o In 20 out of 20 (100%), the name(s) of all alleged victims and perpetrators; o In 20 out of 20 (100%), the names of all persons interviewed during the investigation; o In 20 out of 20 (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 20 out of 20 (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	

#	Provision	Assessment of Status	Compliance
		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. DFPS raised questions about this finding in the State's comments related to the draft report, as well as during the December 2012 parties' meetings. As agreed upon at the parties' meetings, the Monitoring Teams will further discuss this issue. However, as indicated in the draft report, adequate information was not included in the reports to allow the Monitoring Team to assess whether adequate review was completed of previous investigations. o In 20 out of 20 (100%), the investigator's findings; and o In 20 out of 20(100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations involving serious incidents: ▪ In eight out of 10 investigations reviewed (80%), 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 and 12-177. ▪ The report utilized a standardized format that set forth explicitly and separately: o In 10 out of 10 (100%), each serious incident or allegations of wrongdoing; o In 10 out of 10 (100%), the name(s) of all witnesses; o In 10 out of 10 (100%), the name(s) of all alleged victims and perpetrators; o In 10 out of 10 (100%), the names of all persons interviewed during the investigation; o In 10 out of 10 (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 10 out of 10 (100%), all documents reviewed during the investigation; o The previous histories of both the individual and the alleged perpetrator were listed in seven out of 10 investigations (70%). It was	

#	Provision	Assessment of Status	Compliance
		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 10 out of 10 (100%), the investigator's findings; and o In 10 out of 10 (100%), the investigator's reasons for his/her conclusions. A finding of noncompliance again has been made due to issues related to the basis for the findings in 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 supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of the DADS and LBSSLC policies referenced above, 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, 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 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 still noted where timely review had not been documented in the record and instances in which an adequate basis for the findings was missing, the Facility was clearer in its understanding of what was required for complete and adequate investigations and was working towards meeting these expectations. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ In 20 out of 20 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. When the Monitors met with DFPS in April 2012, DFPS indicated it would submit a proposal to address this issue. ▪ There was evidence of the Facility Director's review, and of her Review Team's attempts to clarify or correct certain conclusions. Each investigation file contained a review sheet bearing the signatures of the Incident Management Coordinator, the Director and other leadership staff, indicating that the investigation file was reviewed and approved. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ In 10 out of 10 investigation reports reviewed, evidence was found that the supervisor had conducted a timely review of the investigation report. However, the reviews had not conducted in the identification of concerns the Monitoring team identified for two of the Facility-only reports (i.e., lack of adequate basis for conclusion in 12-121 and 12-177). Thus, an adequate review was conducted for eight out of 10 (80%). It was positive that on a supervisor's review page, 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. However, work was needed to ensure these reviews identified concerns in the investigations. 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, as well as concerns with regard to the adequacy of the Facility's review process.	
	(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	In its investigation report files, the Facility included copies of correspondence related to disciplinary action. The review of 30 files in Samples #D.1 and #D.2 indicated the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	termination of employees confirmed to have committed abuse or neglect. Ten staff were terminated from employment as the result of the findings from the investigations. Other disciplinary actions included suspension and performance counseling. As discussed earlier in this report, the Facility had begun to track the reassignment of alleged perpetrators and any ensuing disciplinary actions. The lack of a reliable tracking mechanism, as identified by the Facility itself, has contributed to the finding of noncompliance. For 25 out of 30 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 thoughtful and sensitive approach to supporting Individual #154 after he was mistreated. Appropriate attention was given to his emotional state and his need to feel more secure. ▪ Counseling support was provided following a sexual incident between two peers. ▪ An investigation into the availability of sufficient grooming supplies for the individuals in one residence resulted in a thorough review of their needs and wishes for personal hygiene care. The following provide examples of investigations for which it did not appear prompt and thorough programmatic action had been taken: ▪ In 12-138, there was no information documented as to the outcome of the peer review regarding the alleged failure to provide pain medication. ▪ In 12-201, there was an inadequate examination of the reasons why individuals remained in their rooms rather than in the common areas of the residence. ▪ In 4134527, there was no evidence as to why an incomplete body assessment was performed or the corrective actions to be taken as a result. ▪ In 42141073, there was no explanation as to why an individual was not moved to another residence after instruction from the ADOP. 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.	

#	Provision	Assessment of Status	Compliance
		Because the Facility did not establish specific measureable objectives for corrective actions or the implementation of recommendations, it was sometimes difficult to determine if the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. The following are examples of the recommendations' outcomes were easier to track: ▪ Ten employees were terminated as a result of findings from the investigations where abuse and/or neglect were confirmed. The following are examples of where it was difficult to determine if the outcomes had been achieved through the implementation of the programmatic and/or disciplinary action: ▪ Although in-service training was provided, it was difficult to determine if staff competencies actually were increased as a result. ▪ Stress related to the high rate of staff turnover in the residential units did not appear to have been addressed as a potentially contributing factor.	
	(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, the space has remained secure and accessible to the investigators as needed. An expansion of storage space had been implemented. The new space was located at the Facility and was accessible only to the investigative personnel. The Facility remained in substantial compliance with this provision.	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. Since the last site visit, the Incident Management Coordinator, the Risk Manager, the Director of Behavioral Services, and the Director of Quality Assurance had worked together to produce more detailed reports regarding serious injuries, incidents, and restraints. Each of these critical concerns was 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 and incidents. A system to track follow-up in individual cases had been initiated. Responsibility and timeframes were identified in each case.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There was evidence that a system for trending and tracking had been implemented. All unusual incidents and investigations were reviewed daily at the Incident Management Review Team meeting. Trend reports were produced and discussed at the Executive Safety Committee and the Quality Assurance/Quality Improvement Council. The Incident Management Coordinator and the Risk Manager were assigned responsibility for tracking incidents, investigations, and injuries. The Director of Behavioral Services tracked restraint use. Since the last site visit, the data regarding incidents, injuries, and restraints was summarized and compared in order to identify any trends. The Facility was in the beginning stages of developing and implementing specific action plans to address identified trends, which is a key component of a tracking and trending process. Without it, the Facility cannot reach the expected outcome of Section D of the Settlement Agreement: to protect individuals from harm consistent with generally accepted standards of practice. One example of the Facility's efforts to utilize information included review of data related to the location and timing of injuries by day of the week and by shift, and then to begin to target specific residences or locations on campus for further attention. However, more work was needed to analyze data and develop specific plans related to individuals, residences, staffing, etc. to adequately address issues identified. For example, with regard to trends related to peer-to-peer aggression, action plans should be developed and implemented, including consideration as appropriate for separating individuals into different living and day program environments. In addition, when trends show issues with particular residences or homes, further analysis should be conducted and specific and substantive actions developed and implemented to remedy the issues identified, for example, related environmental factors, such as the number of individuals living in a residence, that contribute to the incidents and injuries. In addition to ensuring that these plans are adequate to address trends and include measurable outcomes, next steps include tracking the status of the plans, and ensuring their completion and effectiveness at addressing the trends. It is essential that if trends are identified, adequate actions are taken. Although important progress had been made, the Facility had not yet achieved compliance with this provision.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	As discussed in earlier reports, the State Office and the Facility Director had worked together to implement a stringent process to track the investigation of the backgrounds of Facility employees and volunteers. Extensive documentation was provided to verify that each employee and volunteer was screened for any criminal history. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to random drug testing. New employees were required to undergo fingerprint checks. The Facility received a "rap back" providing any updated information regarding current employees who had been fingerprinted previously. The Facility conducted its annual employee registry check and criminal history submission in October 2012. Also, the Facility submitted documentation indicating that background checks were conducted on volunteers. Two employees received bars to employment. One resigned in lieu of termination, and the other was placed on emergency leave and was attempting to have the charges dropped. A random sample of 20 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. The Facility remained in 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 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 and/or IDTs should review DFPS reports and ensure that all concerns raised are addressed through recommendations in the Incident Management Report that accompanies each investigation and/or an ISPA.
    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)
3. 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)

4. 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)
5. 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 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: ▪ **Review of Following Documents**: o Presentation Book for Section E, including blank monitoring forms for each of the sections of the Settlement Agreement, Corrective Action Tracking Plans, and presentation slides from the training sessions on Quality Assurance/Quality Improvement conducted by H&W Independent Solutions; o DADS Policy Number 003.1: "Quality Assurance," dated 1/26/12; o Quality Assurance/Quality Improvement Council meeting minutes, dated from 3/21/12 to 7/26/12; o LBSSLC Policy "Review Processes: Quality Assurance Process/Plan," dated 8/30/12; o Plan of Improvement/Self-Assessment, updated on 8/22/12; o Quality Assurance Plan, revised 8/29/12; o Settlement Agreement Compliance Reports, including inter-rater reliability score sheets and Quarterly summaries, completed by the Facility for all sections of the Settlement Agreement, dated from 3/12 to 7/12. ▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs (ADOP); o Dawn Ripley, Director of Quality Assurance (QA); o Jim Forbes, M.Ed., C.B.A., Director of Behavioral Services; and o Rodney McWilliams, Incident Management Coordinator. ▪ **Observations of**: o Executive Safety Committee meeting, on 10/3/12; o Incident Management Review Team meetings, on 10/2/12, 10/3/12, and 10/4/12; and o Quality Assurance/Quality Improvement Council meeting, on 10/3/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, updated on 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section E, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o Based on review of the Facility's Self-Assessment, the Facility conducted a review of some important components of the quality assurance system, including, for example, some key meetings and meeting minutes, such as the QA/QI Council Meeting and the Executive Safety Committee meeting, as well as Corrective Action Plans (CAPs) and documentation related to their implementation. o The current review process for Section E did not include adequate indicators to allow the

	Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional areas that are relevant to making compliance determinations. o The Self-Assessment generally identified the sample(s) sizes, including the number of meetings/records (e.g., CAPs) reviewed in comparison with the number of meetings/records in the overall population (i.e., n/N for percent sample size). These sample sizes were generally adequate to consider them representative samples. In most cases, all relevant information was reviewed (e.g., all current CAPS, all meetings held, etc.). o The following staff/positions were responsible for completing the audit tools: Program Compliance Monitors from the Quality Assurance Department and clinical staff identified by the Departments/disciplines worked collaboratively. o The staff member responsible for conducting the audits/monitoring was programmatically competent in the relevant area(s). ▪ Did use some relevant data sources and/or key indicators/outcome measures. The Facility, for example, used its tracking log for CAPs as part of its assessment of its compliance with Section E. As the Facility noted in its Self-Assessment, it was awaiting further guidance from State Office regarding the development of key indicators. However, the Facility had done some work regarding key indicators related to medical care, which is discussed further in relevant sections. ▪ Although as noted above, more information was needed with regard to the Facility's compliance with Section E, the Facility presented the data it did have in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Generally presented findings consistently based on specific, measurable indicators. However, this continued to be an area in which improvement was needed. Particularly, focus was needed to better define additional measurable indicator. As one example, the Facility noted that each CAP did not contain a measurable outcome. However, this was not quantified to provide the Facility with a measure of whether or not it was improving. o Although this is an area that will need continued work and more definition, for Section E, some efforts were made to measure the quality as well as presence of items. For example, in looking at CAPs, the Facility looked at whether they were resulting in the desired outcome as well as their timely completion. However, at other times, just the presence or timeliness was the focus. For example, the quality of the discussions and activities of the QA/QI Council were not fully evaluated, but rather just that the meetings had occurred at a certain frequency. ▪ The Facility rated itself as being in compliance with the following sub-section of Section E: Section E.3. This was consistent with the Monitoring Team's findings. ▪ The Facility data did identify limited areas of need/improvement. However, except for some brief explanations (such as an indication that State Office would be providing more guidance on the development of key indicators), there was no reference to action plans that specifically addressed the deficits identified, or analysis of the underlying issues.
	Summary of Monitor's Assessment: Since the Monitoring Team's last visit, the Facility continued to take action to strengthen the Quality Assurance process and to ensure that leadership staff and the members of

	the Quality Assurance/Quality Improvement Council reviewed subsequent findings on a periodic basis. Clearly, the design and implementation of an effective and sustainable quality assurance process remained a priority at LBSSLC. Although still incomplete, there was evidence that the Facility had implemented a number of appropriate and effective monitoring and evaluation strategies in order to achieve compliance with the outcomes of the Settlement Agreement. For example, Quality Assurance staff and staff from the Departments and clinical disciplines worked together to review such important aspects of care as lifting techniques, the maintenance of emergency equipment, and the completion of restraint checklists. The role and value of an effective Quality Assurance Department seemed better understood on a Facility-wide basis. As a result, there was a notable level of cooperation and collaboration expressed to the Monitoring Team during the course of the onsite visit. One of the primary concerns noted during the onsite visit continued to be the lack of established key indicators and/or outcome measures. According to information obtained during the review, in July, the State Office assumed responsibility for the determination of the final set of key indicators and/or outcome measures. However, this work had not been finalized and the Facility was unable to provide a status report or a timeframe for completion. The failure to determine a set of key indicators will most certainly affect the Facility's ability to move forward with its establishment and implementation of a comprehensive quality management system. For example, as reported previously, it was the Monitoring Team's assessment that the Facility had identified data that was being or could be collected. However, in the absence of key indicators and/or outcome measures, the collected data was not sufficiently linked to the Facility's programmatic goals, such as health, safety, and meaningful lives for the individuals who reside at LBSSLC. The absence of key indicators and outcome measures undermined the Facility's expressed desire to establish adequate and substantive goals and benchmarks. As noted in the last report, the Facility's resources, staff expertise, the design of the campus, and community resources would affect the established goals and benchmarks. These variables should be organized and directed to assist with the attainment of the short and long-range goals and outcomes. Moreover, as the Monitoring Team previously noted, a comprehensive Quality Assurance 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 State Office works to finalize these outcome measures, the Monitoring Team continues to recommend an incremental approach to implementation, so that any necessary adjustments can be made effectively and in a timely manner. Review of the monthly minutes of the Quality Assurance/Quality Improvement Council and attendance at one of its meetings continued to demonstrate the importance and effectiveness of this organizational structure. The agendas consistently focused on achievement of compliance with the provisions of the Settlement Agreement. Corrective Action Plans (CAPs) were identified, refined, and tracked. Changes in the CAPs required discussion and consensus. As a result, there appeared to be a more deliberative approach to problem identification and resolution. The discussion was enriched by the depth of knowledge about individuals and program processes held by some Council members. In addition, the combined

	presentation of related information, such as the data regarding incidents, injuries and restraint use, permitted a fuller perspective of the risk factors present at LBSSLC and, consequently, a more effective elaboration of remedial strategies. At the time of the site visit, the CAP Tracking Log documented that there were twelve remedial actions in the process of completion or continued monitoring. The focus of the CAPs included: strengthening the competencies of frontline managers; improving the content and use of nursing protocols; retraining staff on recordkeeping practices; ensuring that the Individual Support Plan identified the most integrated living option; reducing the number of restraints and injuries; reducing the number of tertiary care and clinic visits; and decreasing the turnover of direct support professionals. The CAP Tracking Log included the date of the CAP's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. However, as noted previously, 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. Although expected outcomes were defined, they were not stated 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, continuing progress in the development of a strong Quality Assurance system again was evident. The Monitoring Team commends the Facility's continuing efforts in striving to achieve compliance with these mandates of the Settlement Agreement. The Monitoring Team also reiterates its recommendation that the State Office proceed expeditiously to finalize key indicators and/or outcome measures, so that realistic and appropriate goals and benchmarks can be established at the Facility and aid its intent to reduce risk and strengthen habilitation and protection from harm.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	DADS Policy Number 003.1 was issued on 1/26/12. On 8/30/12, the Facility revised its own policy entitled: "Review Processes: Quality Assurance Process/Plan." The policy addressed all requirements of the Settlement Agreement and the State policy. Evidence was provided to confirm that relevant staff, including senior management and Quality Assurance staff, had been trained on the revised policy. The Facility had designated a Quality Assurance Director. She and her staff had worked in collaboration with Department and discipline leadership to become knowledgeable about the specific requirements of each section of the Settlement Agreement in order to develop and implement applicable monitoring tools and protocols. On 8/29/12, the Quality Assurance Plan was revised. The purpose of the Plan was "to produce written documentation describing how data will be acquired, analyzed, evaluated and assessed against its intended use and the quality performance criteria."	Noncompliance

#	Provision	Assessment of Status	Compliance
		The matrix documented the elements of the Quality Assurance process by identifying how and when quality assurance system audits would occur. For each provision of the Settlement Agreement, the matrix defined the person responsible for the respective section; the audit tool; the frequency of the review; sample size; the staff responsible for auditing, analyzing, and reporting data; and the process for reviewing results and developing/monitoring any Corrective Action Plans. However, 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 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 Quality Assurance/Quality Improvement Council. As noted in the last report, the Facility was in the very beginning stages of this, and had not actually developed outcome measures, but actually had just begun the process by identifying its data list/inventory. This was an important first step, and during the last review, Facility staff and the Monitoring Team discussed in detail next steps to developing key indicators or outcome measures using this as the basis. However, according to Facility staff, in July 2012, the State Office assumed responsibility for this critical set of decisions. The work was not completed at the time of the site visit, and the status of this initiative and its anticipated timeline was not known. According to the matrix, all data obtained through the respective monitoring protocols were to be submitted to the Quality Assurance Department for review and analysis of the results. Based on discussion and the review of documentation submitted by LBSSLC. The Facility was implementing its recently updated Quality Assurance Plan as written. Quality Assurance staff assigned to the respective Departments/disciplines collected data and reviewed it on a regularly scheduled basis. As is discussed in other sections of this report, these discussions were of varying quality. One of the areas in which continued focus was needed related to the analysis of data collected, and discussion with clinical and programmatic staff about the potential underlying reasons for deficits identified.	

#	Provision	Assessment of Status	Compliance
		The degree to which monitoring was to be delegated to the Departments and disciplines was still under discussion at the time of the onsite visit. It was clear that collaboration and cooperation existed among the various staff involved in these assignments. The Facility provided the copies of monitoring tools currently in use. These included: Supervision Monitoring Tool; Emergency Drill Checklist; Emergency Oxygen Tank and Suction Machine(s) Checklist; Lifting/Transfer Monitoring Tool; Monitoring Tool for Section C (Restraint); Monitoring Tool for Section D (Abuse, Neglect and Incident Management); Monitoring Tool for Section F (Integrated Protections, Services, Treatments and Supports); Monitoring Tool for Section K (Psychology); Psychiatric Care and Services Monitoring Tool; Medical Provider Quality Assurance Audit; Nursing Assessment and Care Plan Annual Audit; Medication Administration and Documentation Audit; Audit for Acute Infections; Universal Monitoring Tool for Sections O, P and R; Monitoring Tool for Section S (Habilitation, Training, Education and Skill Acquisition Programs); Monitoring Tool for Section T (Planning for Movement, Transition and Discharge); Monitoring Tool for Section U (Consent); a Satisfaction Survey, Section E - QA Tool, Section I - At Risk, Medical Management tools used during medical provider QA audit, Annual Nursing Assessment, Acute Illness and Injury, Nursing Care - Documentation, N-1 Drug Interaction Interventions, Quarterly Drug Regime Reviews, Section Q - Dental, Section T - Post Move Monitoring, Section T - Review of CLDP, Section V - Recordkeeping, Record Guidelines Checklist, Check out Check In form, Submission and Filing Tracking Sheet, Investigation Results Notification, DNR Monitoring, Consumer Observation and Interview Tool, X-ray Checklist, and Emergency Response Drill Equipment Checklist. The Quality Assurance Director has worked closely with the members of the Quality Assurance/Quality Improvement Council to review the monitoring tools, their instructions and the schedule for implementation. It was noted that changes in Departmental staffing and staff vacancies had affected the timely implementation of certain monitoring tools, such as those for Section I. As noted throughout this report, including in narrative sections of the report as well as the Facility Self-Assessment sections, the Monitoring Team continued to note many concerns with regard to the monitoring tools and their implementation. It was positive that LBSSLC staff were looking critically at the tools and making changes, appropriate. The Monitoring Team continues to emphasize the need to develop adequate instructions to ensure valid results, and ensure staff completing the tools are trained and clinically/programmatically competent. Inter-rater reliability was tested and the results were provided with the analysis of the monitoring tool results. Although improvement was noted, it was not consistent across all monitoring tools. Inter-rater reliability was not tested for Section F during the months of 4/12 through 7/12 due to Departmental changes. Attention to this issue was evident, however, and it was clear that the establishment of acceptable inter-rater	

#	Provision	Assessment of Status	Compliance
		reliability continued to be a priority for the Director of Quality Assurance. A procedure detailing the inter-rater reliability process was completed on 9/15/12. Staff training was to be completed by 10/15/12. Although the Facility acknowledged, and the Monitoring Team concurred, that substantial work remained, progress in the requirements of this provision was noted.	
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.	LBSSLC had continued to move forward with the actions required to achieve compliance with this provision. The Quality Assurance Department expected to complete a standardized analysis format for sharing monitoring results by 10/15/12. Once that format was completed, reports summarizing the monitoring results were to be issued beginning in 1/13. The structure for the Corrective Action Plans was under review in order to include measureable outcomes to address the identified issues and to allow for an accurate review of the efficacy of the Corrective Action Plan. This work was underway at the time of the site visit. It was to be completed by 10/30/12. However, in reviewing the Monitoring Team's report from the prior site visit, it was noted that timeframes for the requirements of this provision had been extended. For example, previous action plans projected development of a standardized analysis format for sharing monitoring results by 7/31/12. By 3/31/12, required components of the Corrective Action Plans, including measureable objectives, were to be identified, and by 4/30/12, approval was to be sought from the Quality Assurance/Quality Improvement Council. Notwithstanding the work still to be completed, the Facility had made a substantial effort to analyze data from its monitoring and to develop trend reports. These reports were reviewed during the site visit during the meetings of the Executive Safety Committee and the Quality Assurance/Quality Improvement Council. The trend reports were compiled through the efforts of the Risk Manager, the Director of Behavioral Services and the Incident Management Coordinator. The reports analyzed the occurrence of injuries, incidents, and restraints across and within program areas, living units, work shifts, and the time/day of occurrence. In addition, individuals with higher rates of injury, incidents and/or restraint were reviewed, as were certain staff involved in the incident or episode. The analysis of information across three major areas of protection from harm was a substantial step in understanding the inter-relatedness of the living environment, staff practices, and habilitation. The collaboration between the three Departments is to be commended, and serves as a model for similar efforts by other disciplines.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition to the trend reports, the Quality Assurance Department had issued Settlement Agreement Compliance reports for each of the Sections. These reports described the results of inter-rater reliability comparisons and the overall results of the monitoring tools. These reports were useful. However, they would benefit from discussion about the utilization of the acquired information and its impact on ensuring health, safety, habilitation, and improved quality of life for the individuals residing at LBSSLC. Without fuller discussion, there is a lack of substance regarding the array of systemic issues and areas requiring improvement, as well as the potential underlying causes. Such an analysis is necessary to ensure that meaningful corrective actions are identified and undertaken. Based on the review of minutes and attendance at one meeting, it was apparent that the regularly scheduled and fully represented Quality Assurance/Quality Improvement Council continued as a relied-upon partner in the efforts 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. At the time of the site visit, workgroups had been formed to address the high rate of turnover for direct support professionals, the enhancement of frontline staff competencies, and the competencies of mealtime coordinators. Corrective Action Plans continued to be developed in response to the reports generated from the monitoring reviews. Consensus of the Council was sought for approval of the Corrective Action Plans, extensions to deadlines, or the formation of additional workgroups. At the time of the onsite visit, the Corrective Action Tracking Log documented that there were twelve formal Corrective Action Plans in the process of completion or continued monitoring. The focus of the Corrective Action Plans included, for example: strengthening the competencies of frontline managers; improving the content and use of nursing protocols; retraining staff on recordkeeping practices; ensuring that the Individual Support Plan identified the most integrated living option; reducing the number of restraints and injuries; reducing the number of tertiary care and clinic visits; and decreasing the turnover of direct support professionals.	

#	Provision	Assessment of Status	Compliance
		Review of the twelve Corrective Action Plans indicated, which represented 100% of the CAPs the facility identified had been developed: ▪ Twelve (100%) included the actions to be taken to remedy and/or prevent the reoccurrence; ▪ Twelve included the anticipated outcome of each action step. However, although expected outcomes were defined, they were not stated in measurable terms to allow decisions to be made with regard to their success or the need for the Plans to be revised. As a result, the CAPs did not sufficiently address this requirement of the Settlement Agreement provision; ▪ Twelve (100%) included the person(s) responsible; and ▪ Twelve (100%) included the time frame in which each action step must occur. The Corrective Action Plan Tracking Log included the date of the Corrective Action Plan's inception, as well as the person ultimately responsible for ensuring the completion of each assigned task. However, as noted previously, potential barriers to the implementation of a Corrective Action Plan 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, progress continued to be made.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Corrective Action Plans were disseminated to entities/personnel responsible for implementation. The Corrective Action Plan Tracking Log included the date of the Corrective Action Plan'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 Quality Assurance/Quality Improvement Council session held during the Monitoring Team's onsite visit, content and responsibilities for the completion of the Corrective Action Plans, as assigned, was discussed routinely at these meetings. 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 Corrective Action Plan 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 Quality Assurance/Quality Improvement Council cannot be assured that serious issues have been resolved.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 last site visit. However, the time frame for completion was extended to 11/1/12. Once the above action was completed, the Quality Assurance/Quality Improvement Council was to monitor Corrective Action Plans for measurable outcomes in order to determine their effectiveness at remedying the identified problems. The projected completion date for this action step was now listed as 12/1/12. 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.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	At its monthly meetings, it was documented that the Quality Assurance/Quality Improvement Council reviewed Corrective Action Plans. On 5/15/12, the Facility began to implement its intent to develop a process for the review of the effectiveness of Corrective Action Plans. This development is projected for completion by 11/1/12. The Quality Assurance/Quality Improvement Council is projected to monitor Corrective Action Plans that include measurable outcomes to determine the effectiveness of the Corrective Action Plan in addressing the identified issue or to determine whether revisions are necessary. This work began in 5/12 and was to be completed by 12/1/12. It was in process at the time of the site visit. As noted above, the Facility should continue to focus on ensuring that clear measures are defined, including outcome measures, to allow the Quality Assurance/Quality Improvement Council to determine when a Corrective Action Plan has been successful, and when one needs to be modified.	Noncompliance

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

1. The Settlement Agreement monitoring tools should continue to be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the enhancement of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, 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: ▪ **Review of Following Documents**: o DADS Draft Policy Number 004: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, undated; o DADS State Supported Living Centers Procedure – Instruction for Preferences and Strengths Inventory (PSI), undated; o Preferences and Strengths Inventory template, undated; o ISP Preparation Meeting instructions, undated; o Individual Support Plan Preparation Addendum, undated; o Draft Annual ISP Meeting Interdisciplinary Team (IDT) Attendance Indicators, revised 7/20/12; o Draft Assessment/Report Schedule – Minimum Requirements, dated 7/20/12; o Assessments/Reports Needed for Annual ISP Meeting and IDT Members Required for the Annual ISP Meeting template, revised 6/14/12; o Instructions for ISP Meeting Guide, revised 9/7/12; o ISP Meeting Guide, undated; o Individual Support Plan Planning Circle, dated 4/6/12; o Presentation Book for Section F; o LBSSLC Self-Assessment, updated 9/17/12; o ISP 30-Day Compliance Data, for March through September 2012; o Graph of ISP Filing Data, for 3/1/12 through 9/14/12; o List of individuals with: a) number of days between ISPs; and b) number of days before ISP filed in chart, undated; o Most Recent ISP Dates, Dates ISPs were Filed and Previous ISP, undated; o Graph of Attendance Data, for March through September 2012; o ISP Data Reports, for March through September 2012; o Graph of Assessment Data, for March through October 2012; o Assessment Data Report, for March through August 2012; o Individual Support Plan Annual Assessments Spreadsheets, for September 2012 and October 2012; o Draft Individual Support Plans, draft Integrated Risk Rating Forms (IRRF), Preferences and Strength Inventories (PSIs), Pre-ISP Meeting documentation, assessments, and Sign-in Sheets, for Individual #258, and Individual #140; o Monthly reviews for Individual #223, Individual #233, Individual #120, and Individual #98; o Annual Integrated Risk Rating Form, dated 5/31/12; o IRRF Instructions, dated 7/16/12; o Sample Integrated Progress Notes, undated; o LBSSLC Personal Support Plan Facilitation Checklist, revised 3/21/11;

	○ ISP Monitoring Checklist with instructions, dated 4/18/12; ○ Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/23/10; ○ Qualified Developmental Disabilities Professional (QDDP) Training Curriculum, undated; ○ QDDP On-the-Job (OJT), for July 2012; ○ 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: "At this time there are not any actions taken or corrective action plans in regard to monitoring/audited data that the Facility has collected in relation to integrated protections, services, treatments, and supports"; ○ In response to the request for the last 10 monitoring tools the QDDP Coordinator completed, the following statement: "Due to changes in the department in May 2012, the departmental monitoring has been deferred until 11/01/12"; ○ In response to the request for the last 10 monitoring tools the QA Department completed, data summarized on monitoring forms by month, from January through July 2012; ○ Supporting Visions: Personal Support Planning Workbook, dated 7/10; ○ Fact Sheet on Olmstead v. L.C., undated; ○ Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool sample, dated 5/10/11; ○ QMRP Facilitation Skills Performance Tracking, dated 5/24/11 (appears to be incorrect date); ○ QDDP Current Assignments and Number of Individuals on Their Caseload, undated; ○ QA/QI Quarterly Summaries for February through April and May through July 2012, dated 5/10/12 and 8/13/12, respectively; ○ Settlement Agreement Compliance Reports for Section F, for March through July 2012; and ○ Inter-rater reliability summaries for Section F, for March 2012. ▪ **Interviews with**: ○ Sandra Kennedy, QDDP Coordinator; Christina De Los Santos, QDDP Educator; Marc Lopez, ISP Technician; Tracey Snow Murphy, Director of Residential Services; Paul Thomas, Director of Recreation/Active Treatment; Carolyn Milton, Assistant Director of Behavioral Services; and Jim Forbes, Director of Behavioral Services, on 10/3/12. ▪ **Observations of**: ○ ISP meetings for the following: Individual #140, and Individual #258.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section F, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed

	monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: LBSSLC Personal Support Plan Facilitation Checklist, revised 3/21/11; Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/23/10; and the Settlement Agreement Cross-referenced with ICF/MR Standards: Section F – Integrated Protections, Services, Treatments, and Supports. Based on discussions with the QDDP Coordinator, it was anticipated that State Office would finalize a new monitoring tool soon that would correspond with the revised ISP process. o Thee current monitoring/audit tools included indicators to allow the Facility to determine compliance with the Settlement Agreement, but it was not always clear what the connection was between the monitoring tools and the Self-Assessment. In addition, although the Facility Self-Assessment included many measurable objectives, in a number of sections, adequate indicators were not included. For example, Section F.2.a.1 of the Settlement Agreement includes a number of requirements. The Facility's Self-Assessment only addressed some (e.g., explanation of any need or barrier not addressed) and not others (e.g., prioritization of needs), and others did not have indicators that were discrete enough to provide valuable data (e.g., an indicator related to supports and services to address community participation). Similarly, for Section F.2.a.2, the Self-Assessment did not address the quality of ISPs in addressing the needs of individuals, which is a major component of compliance with this provision of the Settlement Agreement. As new/revised monitoring tools are considered, the State/Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o As noted above, the monitoring tool(s) was under revision. However, based on review of the current tools, they generally included adequate methodologies, such as observations, and record reviews. However, these methodologies were not specified with regard to specific indicators. As a result, it was likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). This sample sizes generally were adequate to consider them representative samples (e.g., 10% of the 121 ISP meetings held). However, to ensure a good cross-section of ISPs, consideration should be given to selecting one from each QDDP. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. At the time of the Monitoring Team's last review, the Facility had made a 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. However, at the time of the October 2012 review, no revised instructions for the monitoring tools were available. This was understandable given the change in leadership in the QDDP Department, and other priorities. However, this is an

	important task that should be completed, particularly as new monitoring tools are developed. o The following staff/positions were responsible for completing the audit tools: a Program Compliance Monitor from the QA Department and the QDDP Coordinator. However, due to changes in the staffing of the QDDP Department, the QDDP Coordinator's monitoring had been put on hold until November 2012. o The staff responsible for conducting the audits/monitoring had not been formally deemed competent in the use of the tools. Although the staff responsible had experience with developing and implementing ISPs, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o As the Facility recognized, adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. The fact that the QDDP Coordinator's monitoring responsibilities had been put on hold had understandably delayed this process. ▪ LBSSLC used other relevant data sources and/or key indicators/outcome measures. For example, the Facility maintained a Word document and was developing a database to track the timeliness of assessments, as well as attendance at ISP meetings. Some of this information was included in the Self-Assessment. Moving forward, it will be important to ensure that the data specified in the Self-Assessment is discrete enough to identify areas requiring attention. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not consistently present findings based on specific, measurable indicators. In some instances, the Facility presented overall compliance scores. For example, the Facility provided the data related to attendance as overall scores for each month. Although the narrative indicated that individuals, guardians, and direct support professionals often were the ones not in attendance, it was unclear from data presented to the Monitoring Team as part of the document request process whether or not data was being maintained in relation to all disciplines that might need to attend a meeting depending on the individual's needs. Providing more specific data in the Self-Assessment would provide useful information to the Facility in identifying specific disciplines that were not attending ISPs regularly. In addition, for Section F.2.a.3, the finding was presented in the negative, making it more difficult to calculate the rate of compliance. o Did not consistently measure the quality as well as presence of items. It was not consistently clear whether or not the quality of the ISPs was being assessed. As just one example, for Section F.2.a.3, an indicator addressed whether or not the ISPs included "a risk rating tool that integrated all the protections, services and supports." It was unclear if the quality with which risk rating information was included in action plans in the ISPs had been assessed. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section F. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For these areas of need, the Facility Self-

	Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or drawing connecting between the findings and specific portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. 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: In August 2012, the State Office provided additional training on a revised ISP format and process to LBSSLC's QDDPs and many other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. In addition to the team using a new tool to identify the individual's preferences, strengths, and priorities, at the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or were note successful, then the team was to decide what action to take. The team also was to make decisions regarding which team members should attend the annual meeting, and the assessments that needed to be completed prior to the meeting. At the time of the Monitoring Team's review, two teams had been selected to pilot the new process. Other teams were using a portion of the process, but had not yet fully implemented the revised Integrated Risk Rating Form or integrated health care plans. For the pilot teams, the first meetings using the new process were held the week of the Monitoring Team's onsite review. Beginning with a couple more teams in January 2013, LBSSLC planned to slowly rollout the full process, using the pilot teams as mentors. LBSSLC had developed QDDP Mentoring Quads. They appeared to be a good addition and provided support to QDDPs by involving other QDDPs in taking detailed notes during ISP meetings, and giving QDDPs time to quickly turn around the ISP documents. As part of the ISP Preparation Meetings, teams had begun to more systematically identify the assessments that the individuals required. However, justification was not consistently provided when an individual's needs indicated the need for an assessment, but the team decided not to require completion of that assessment. Timeliness and quality of assessments continued to be problematic. Assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them in the ISPs. The major focus of the ISP meetings the Monitoring Team observed was the risk rating and health care plan development. This is important, but teams will need to find ways to become more efficient with this process, and spend more time developing plans to assist individuals to become more independent and lead full and meaningful lives.

	The quality of teams' discussions about individuals' preferences and strengths, as well as community activities varied, particularly for individuals with more complex needs. Overall, further refinement of these discussions was needed, including expanding the scope and types of preferences and strengths the teams identified, and better incorporating them into the ISP action plans and using them creatively to expand individuals' opportunities or address their needs, as well as increasing individuals' opportunities for community integration through the inclusion of measurable and meaningful objectives in their ISPs. The Facility identified that the development of action plans was an area in which more work was needed, as well as more training and technical assistance. Based on limited observations of ISP meetings while the Monitoring Team was on site, teams were talking more about the various "protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual," and more interdisciplinary collaboration was occurring. Teams clearly were trying to develop measurable action plans, but needed assistance in developing comprehensive plans, as well as measurable and functional objectives. The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs. The Facility had developed a new monthly review format for QDDPs. It was positive that this review included more data related to skill acquisition plans. However, it remained unclear how the Facility would meet 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."

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan Process, and had provided the Monitoring Teams with a draft copy. The three Monitoring Teams were in the process of reviewing the policy, and any comments will be provided jointly. DADS State Office recognized the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups including State Office and Facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. On August 21 and 22, 2012, State Office consultants had provided training on the new process to LBSSLC QDDPs and many team members. In consultation with the parties, it was agreed that beginning in August 2012, the Monitoring Teams would only review and comment on the ISP documents that utilized	

#	Provision	Assessment of Status	Compliance
		the newest process and format. The intention of limiting the Monitoring Teams' review to newer plans is to provide the State and Facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement requirements. LBSSLC began implementation of the new process during the week of the Monitoring Team's review. Two teams at LBSSLC had been selected to begin utilizing the new ISP format, including the revised Integrated Risk Rating Form, and the Integrated Health Care Plan (IHCP) format and process. Although other teams were using the new ISP template/shell, the plan was for the new IRRF and IHCP processes to be slowly rolled out, using the two pilot teams to provide technical assistance to other teams. This appeared to be a reasonable approach. During the week of the Monitoring Team's onsite review, two individuals' ISP meetings were held using the new ISP process, including the use of the new IRRF and IHCP processes. These included the ISP meetings for Individual #258 and Individual #140. Members of the Monitoring Team observed both meetings. As applicable, observations are offered in this report regarding these meetings. Due to the timing of this review and the Facility's recent implementation of the new ISP process, review of ISPs was very limited. Other relevant information was reviewed, and a fuller review of the newer ISP documents will not occur until the next review.	
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 Draft Policy #004.1 in both the definition section and in Section II.F.1.b indicated that the QDDP would assist the individual and Legally Authorized Representative (LAR), as appropriate, in leading the team in an interdisciplinary discussion. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Observations of team meetings also illustrated that the QDDP was the team leader and responsible for ensuring team participation. For both of the ISP meetings the Monitoring Team observed, the individuals had active guardians who participated in the meetings. It was clear that the QDDPs had spent time before the meetings speaking with the guardians. The QDDPs assisted in ensuring that the guardians' concerns, positive comments, and questions were raised and addressed during the meetings. Both individuals also	Noncompliance

#	Provision	Assessment of Status	Compliance
		participated in their meetings. The QDDPs sought the individuals' input as appropriate. ▪ With regard to staffing, since the last review, a number of changes had occurred. A new QDDP Coordinator and a new QDDP Educator had been hired. An ISP Technician also had been hired to assist with data management amongst other duties. This administrative structure was in place to assist in providing QDDPs with needed oversight and training. At the time of the review, there were 11 QDDPs and four vacant positions. Permission had been granted to hire a floater QDDP to assist with leave and turnover in positions. Of the 11 QDDPs, some were fairly new to their positions. When all 15 QDDPs were in place, one QDDP generally would be assigned to each residence. Based on the current census of 211, this would be an average ratio of 1:14, with a range of 1:11 to 1:19. ▪ QDDPs had undergone additional training with a State Office consultant on the new ISP format. This had occurred on 8/21/12 and 8/22/12. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. Copies of the draft were then provided to team members at the beginning of the meeting, and changes were made as appropriate. In addition, more pre-planning began 90 days prior to the ISP meeting. For example, prior to the 90-day ISP Preparation meeting, Active Treatment staff were expected to work with team members who knew the individual best to complete a new Preferences and Skills Inventory, which the QDDPs finalized. The intention of this document was to identify the individual's preferences and skills, as well as priorities so all team members responsible for completing assessments could utilize this information in the assessment process, as well as in developing the ISP. This document would become a living document that would be updated and revised over time. At the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or successful, then the team was to decide what action to take. ▪ At the time of the review, two teams had been selected to pilot the new process, including the use of the revised Integrated Risk Rating Form and development of integrated health care plans. The other teams at LBSSLC were using the new ISP Meeting Guide and the 90-Day ISP Preparation Meeting process. On a rolling basis, beginning in January 2013, the remaining teams were expected to implement the IRRF and integrated health care plan process. The two pilot teams would act as mentors to other teams as they began to use the process. As noted above, the first meetings using the new process were held during the week of the Monitoring Team's onsite review. As a result, comments are based on a sample of only two ISP meetings and related documentation. As is discussed in	

#	Provision	Assessment of Status	Compliance
		more detail in the sections that follow, the new process showed some improvements, but as would be anticipated with a new process, more work was needed to continue to make necessary changes and refine the processes. ▪ The Facility had set up Quad Mentoring Groups. These groups were designed to support one another in a number of ways. For example, in addition to being available to assist with questions or concerns, the groups supported one another by taking typewritten notes at ISP meetings, and covering for one another so that QDDPs could spend an uninterrupted day drafting the final ISP document. By having another QDDP take notes at ISP meetings, it reportedly improved the contents of the notes taken, and allowed the QDDP responsible for facilitating the meeting to concentrate on the meeting. At monthly meetings, the schedules were set up to allow these activities to occur. ▪ During the week of the review, the Monitoring Team observed two team meetings. Progress continued to occur with regard to the facilitation of meetings. Based on these limited observations, some of the areas in which progress had begun or been sustained included: o At annual ISP meetings, an agenda was clearly set forth, along with ground rules. In a few cases, the QDDPs reminded team members of the rules. o Although further improvement was needed, the QDDPs and Nurse Case Managers, included valuable information in the draft ISPs and IRRFs, respectively. o Efforts were made to include the individuals, and focus the discussion on them. o Paper hung on the walls or white boards. This generally was used to list the individuals' strengths and preferences. Although this was a positive practice, there was variability in the extent to which the QDDP referred the team back to this information during the course of the meetings. As a result, for one individual, little to no incorporation occurred of his preferences or strengths into the overall ISP. o The addition of another QDDP, as opposed to a clerk, to take typewritten notes during the meetings helped ensure that important discussion was documented, while still allowing the QDDP to facilitate the meeting. Based on some of the portions of notes that the QDDPs responsible for typing read back to the teams, they were accurately capturing detailed discussion. 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.	

#	Provision	Assessment of Status	Compliance
		o During the ISP meetings on site, the teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. o Based on the observations of the ISP meetings, although problems still existed with the specifics included in action plans, teams were observed discussing action plans in more detail than in the past, particularly some of the strategies that were in place or would be put in place to address risks. Based on observations of two meetings held the week of the onsite review, facilitation of team meetings was improving, but for none of the 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 Facility had been using a tool entitled "Q Construction: Facilitating for Success" to test the facilitation component of competency-based training. At the time of the review, based on a list dated 5/24/11 (although this appeared to be an error), the Facility reported that six of 14 QDDPs had successfully completed the competency check-off. However, this process was about to change. According to staff, State Office had developed the ISP Monitoring Checklist. This would have a dual role of monitoring, as well as assessing QDDPs' facilitation skills. At the time of the review, the new tool was being finalized, and was expected to be available for use later in October 2012. ▪ Based on observations of two meetings held the week of the onsite review and review of related documentation, facilitation of team meetings was continuing to improve. However, as is discussed in further detail below, areas in which QDDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o Expanding the list of individual preferences to include preferences related to work, relationships, past experiences, etc. and using the preferences to offer the individual new experiences. o Similarly, identifying a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. o Making sure decisions the team makes are data-based to the extent possible. A number of gaps continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. It was positive, though, that the teams were discussing objective clinical data in a number of areas. o Developing measurable objectives. As the QDDP Coordinator indicated	

#	Provision	Assessment of Status	Compliance
		during interview, teams continued to struggle with the development of action plan. This factored into the overall process of developing adequate action plans, including appropriate methodologies. o Articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., Individual will attend preferred community outings at least twice a month), rather than as a change in the individual's life (e.g., Individual will make a new piece of artwork at an arts and crafts store in the community, or Individual will participate in a bowling league in the community). o To improve integration of supports, 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. ▪ The ISP meetings the Monitoring Team observed were quite lengthy. In addition, the majority of the time was spent on the risk rating process, including discussion of the integrated health care plans related to the risks. Although this was an essential activity in which teams needed to engage, it resulted in little time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics. Focus should be placed on the preparation before the meetings, so that meeting time is available for both the clinical discussions that need to occur, but also adequate time is devoted to developing supports to assist individuals to expand their independence, involvement in the community, and in leading meaningful lives. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. If action plans were presented in draft format, team members could review them prior to the meeting, and discuss necessary changes and additions at the meeting. Progress had been made. However, based on observations of ISPs meetings, while some aspects of the 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,	DADS Draft Policy #004.1 described the interdisciplinary team as including the individual, the Legally Authorized Representative, if any, the QDDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs, and who are professionally qualified and/or certified	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. This policy statement was consistent with the requirements of the Settlement Agreement. Because the State Office policy had not yet been finalized, at the time of the review, the Facility had not developed a local policy. With the new process for ISPs, at the ISP Preparation Meeting 90 days prior to the ISP, the team was to make a determination regarding whether a team member's attendance was required or not. Moving forward, this information would be included in a database that was being developed. At the time of the review, the Facility's tracking sheet included information from the sign-in sheets. It did not yet incorporate information from the 90-day ISP Preparation Meeting. It also only tracked attendance of the following potential team members: individual, Legally Authorized Representative, QDDP, nurse, psychologist, physician, direct support professional, Residential Coordinator, Contract Local Authority (LA), and Designated LA. Based on the data provided, the Facility was not collecting and/or trending data related to other team members, including but not limited to the psychiatrist, Occupational Therapist (OT), Physical Therapist (PT), Speech Language Pathologist, dental staff, pharmacy staff, active treatment and/or vocational staff, etc. Based on the Facility's Attendance Data report from March 2012 through September 2012, some improvements had been seen, such as physician attendance at meetings. However, low percentages of attendance were noted for other participants, such as individuals, their Legally Authorized Representatives, and direct support professionals. The Facility recognized these issues in its Self-Assessment. (Again, this data did not reflect all disciplines.) Neither in its Self-Assessment or documentation provided regarding quality assurance activities for Section F did the Facility provide an analysis of the potential causes for these groups' lack of attendance, and the Facility's Action Plans included limited action steps to increase attendance of particular groups of Interdisciplinary Team (IDT) members. However, based on interview with the QDDP Coordinator and Educator, some of the homes on campus that supported the individuals with the most complex needs had issues with attendance. Reportedly, some of the steps the Facility was considering included having a meeting room in these homes, and scheduling meetings around individuals' enteral nutrition feeding times. Another action step that the Facility had taken was the development of an ISP Meeting Attendance Memorandum. Based on examples provided, the QDDP would send the memo to IDT members that had been identified as needing to be present at the annual	

#	Provision	Assessment of Status	Compliance
		meeting. The memo would serve the other purpose of summarizing the assessments that needed to be completed prior to the meeting, as well as the individual's preferences, strengths, and goals. This was a positive practice that should be helpful to team members in planning ahead for the annual meetings. Based on the observation of two ISP meetings held the week of the review and the related documentation: ▪ For none of the individuals (0%), at the 90-day ISP Preparation meeting, the team defined the members of the team that should attend the annual meeting. o Although the ISP Preparation Meeting documentation for Individual #140 stated: "The IDT discussed which IDT members will need to attend the ISP meeting. The complete Attendance Sheet will be sent via email with this Summary and is saved with the PSI," the Facility did not provide the Monitoring Team with a copy. Therefore, the IDT members required to attend the meeting could not be confirmed. o For Individual #258, no team discussion of the required team members was documented in the ISP Preparation Meeting summary. ▪ Both individuals had strengths, preferences, or needs that would have required additional team member participation. For none of these two individuals (0%), the team had adequately justified why such team members' participation was not necessary. ▪ For none of the two (0%), it appeared that a duly constituted team participated in the annual meetings. Concerns included: o For Individual #258, no representative from the dental office was present, nor did a direct support professional participate in the annual meeting. The team identified Individual #258 as being at high risk with regard to dental concerns. o Similarly, Individual #140 was rated at medium risk for dental, and no dental staff were present. The QDDP had talked to the dentist before the meeting, which was positive. However, without documentation of team discussion at the ISP Preparation Meeting, it could not be determined if adequate justification existed for a member of the dental staff not attending the meeting. Although the Facility was continuing to populate its ISP attendance database, was in the initial stages of formally identifying team members that needed to be present at ISP meetings through the 90-day ISP Preparation 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	Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included:	Noncompliance

#	Provision	Assessment of Status	Compliance
	response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	▪ DADS Draft Policy #004 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the 'Action Plans' section of the ISP." In Sections II.B and III.C, the policy stated: o "Ninety days prior to the annual ISP meeting… The IDT identifies what assessments need to be completed based on the resident's preferences, strengths, needs, and risks, in addition to ICF/ID required assessments. The IDT should use the guidelines outlined in Exhibit A: Assessment/Report Schedule when determining which assessments should be completed or updated. All assessments should incorporate and reflect the individual's preferences, strengths, and needs… o IDT members complete the recommended and required assessments and place them in the facility computer share drive for the IDT to review no later than 10 working days before the annual ISP meeting. Copies of the assessments will be shared with the resident's LAR, family, actively involved person, or designated representative prior to the ISP meeting…" ▪ Included in some of the training materials was a Draft Assessment/Report Schedule – Minimum Requirements, dated 7/20/12. Although it will be important to ensure that this document addresses the Settlement Agreement as well as regulatory requirements, it appeared to provide a good framework from which teams could work to determine the standard assessments that should be completed, and the timeframes for their completion. ▪ Moving forward, the assessments that teams decided were necessary for each individual's annual ISP meeting would be included in the assessment database. However, at the time of the review, no State Office database was available for entering assessment information. The ISP Technician was calculating compliance with the 10-day timeframe for the submission of assessments using a Facility-developed spreadsheet. It was positive that this data was available, because it clearly identified disciplines that were not submitting timely assessments. In addition to sending emails requesting late assessments, the QDDP Department was sending the aggregate data to discipline heads on a monthly basis. For some disciplines (e.g., psychology, OT, PT, and SLP), these efforts, in conjunction with the meetings on the ISP process State Office held in Austin in September 2012, appeared to have had a positive impact on the submission of timely assessments. For other disciplines (e.g., nursing, medical, and dental), improvement had not yet been seen.	

#	Provision	Assessment of Status	Compliance
		The Facility as well as State Office recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address, psychology (Section K), nursing services (Section M), physical and nutritional supports (Sections O), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychiatry and speech and language assessments. Reportedly, the State Office was developing a list of quality indicators for each of the discipline-specific assessments. 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. Based on the observation of two ISP meetings held the week of the review and the related documentation: ▪ For two (100%) (i.e., Individual #258, and Individual #140), at the 90-day ISP Preparation meeting, it appeared the team defined the assessments that were needed for the annual meeting. However, concerns noted included: o For Individual #140, the team's list of needed assessments was referenced in, but not attached to the ISP Preparation Meeting documentation. Therefore, the Monitoring Team could not determine which assessments the team had decided were necessary. ▪ The teams for none of the two individuals (0%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. Concerns noted included: o As noted above, for Individual #140, the documentation submitted was not complete. o For Individual #258, it was unclear why the team did not require the completion of a vocational, day program, and/or recreation assessment. The team made a number of references in the PSI and ISP Preparation Meeting Summary to the need to involve him in some activities off the home. However, no assessment was requested. Moreover, during the ISP meeting the Monitoring Team observed, the team devoted only a couple of minutes to discussion about possible daytime activities for Individual #258. No justification was provided in either the ISP Preparation Meeting documentation or during the ISP meeting for not conducting an assessment and/or providing Individual #258 with a full-day or part-time schedule of day program or vocational activities.	

#	Provision	Assessment of Status	Compliance
		The ISP Preparation Meeting documentation should include a justification when teams are not requiring completion of an assessment for which the individual has specific needs. ▪ For none of the two (0%), the necessary assessments were completed and available to the teams at least ten working days prior to the ISP meeting, as ABSSLC required. Concerns noted included: o For Individual #140, the following assessments were not timely: Water Safety Assessment, speech, and nursing. The Functional Skills Assessment (FSA) and psychiatric assessment were not submitted for review, so their timeliness and/or availability could not be assessed. Only a dental progress note (not an assessment) was submitted. o For Individual #258, no FSA was submitted. The dental assessment was not submitted timely. Assessments also frequently did not include adequate recommendations. Some of the issues noted included: ▪ Some assessments typically included no or limited specific recommendations (e.g., nursing, and dental). Others included an incomplete list of recommendations (e.g., medical, psychology, OT/PT, Speech, vocational, etc.). However, as Facility staff noted and the Monitoring Team saw in its limited review of the most recent assessments, some improvements were seen, specifically with regard to OT/PT and Speech assessments (e.g., those for Individual #258, particularly when reviewing the recommendations in conjunction with the supports needed should the individual move to a community setting). ▪ Recommendations frequently were not oriented to the development of action plans. For example, assessments clearly identified protections, supports, and services that the individual needed, and, in many cases were being provided at the Facility. However, these were not translated into recommendations to ensure they were included in Integrated Health Care Plans and/or other action plans. In the past, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, based on the limited observation of two meetings, at times, this appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISP. For example: ▪ For Individual #258, the incident summary in the draft ISP indicated that after two separate hospitalizations, he returned to the LBSSLC with "Multiple	

#	Provision	Assessment of Status	Compliance
		scratches, redness, and rashes to various parts of [his] body," and "Multiple bruising." The causes of the injuries were not noted, and the team did not discuss this in any further detail at the ISP meeting the Monitoring Team observed. At a minimum, the team should have discussed these similar incidents, and determined if further action or communication with hospital staff was necessary. Some progress was noted, because teams had begun to more systematically identify the assessments that the individuals required. Care will need to be taken to ensure that justification is provided when an individual's needs indicate the need for an assessment, but the team decides for a specific reason not to require completion of that assessment. Timeliness and quality of assessments also continued to be problematic. This is an area that will require the concerted efforts of all team members to bring the Facility into substantial compliance.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ Based on the Monitoring Team's observation of two ISP meetings and review of relevant information, neither of the two teams (0%) addressed all recommendations in the assessments either by incorporation of the recommendation into the ISPs, or evidence that the team had considered the recommendation and justified not incorporating it. o For example, for Individual #258, the speech therapy assessment included a number of recommendations and proposed specific skill acquisition goals that the team did not discuss. Similarly, the medical assessment included a list of follow-up that was required, but the team only discussed the components that related specifically to the risk factors on the IRRF. o Similarly, for Individual #140, even with the limited recommendations included in many of the assessments, the team did not address all of the recommendations included in assessments, for example, the nutrition or speech assessments. ▪ Some of the overall continuing concerns negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, an ISP that outlined the protections, services and supports provided to the individual included: o Issues with regard to the quality of the assessments. As noted with regard to Section F.1.c, many assessments included minimal	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommendations. As a result, it was not clear what protections, supports, and services, the assessors had determined the individual required. The assessment results were not translated into recommended action plans, including measurable, functional objectives. o Based on review of documentation and observation of meetings, it was not clear that team members had read each other's assessments and identified questions and/or recommendations related to the integration of services and supports. This limited teams' ability to utilize assessment information to develop adequate protections, supports, and services. The Facility should address these 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. Although not always complete, it appeared that teams had begun to review and incorporate assessment information and clinical data into the decision-making regarding individuals' risk ratings. Based on the ISPs and related assessments submitted, however, assessments continued to lack adequate recommendations to appropriately define the protections, supports, and services the individuals required. In addition, even when recommendations were included, teams did not consistently address them at the ISP meeting or in the ISP document.	
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 8/3/12, as part of the QDDP Department's regular meeting, training/review occurred on Living Options topics, including the revised process for the Inclusion of the Designated Local Authority during Living Options Meetings, adopted 5/3/12; the referral process; and the job functions of the Admissions Placement Coordinator, Post-Move Monitor, and Transition Specialist. ▪ The Transition Specialist had begun to attend the QDDP Department meetings. The minutes showed that she presented a topic(s) at each meeting. 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. However, the following observations are provided based on the Monitoring Team's observation of the ISP meetings for Individual #140 and Individual #258, and review of the related documentation: ▪ Neither of the teams (0%) provided an independent assessment or recommendation related to individuals' ability to transition to a more integrated	Noncompliance

#	Provision	Assessment of Status	Compliance
		setting. In order for the State Office 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 Some assessments included the required statements/recommendation, and others did not. o In assessments that did provide statements, at times, the State Office requirement was not met and/or the assessor did not provide adequate justification for his/her recommendation. For example: ▪ For Individual #258, the SLP assessment did not include a specific statement as State Office required, but stated: "[Individual] is not able to verbally communicate wants and needs (basic or medical) to communication partners. Therefore, [Individual] would benefit from remaining in an environment where he has staff available to anticipate his needs and interpret his communication signals." Similarly, the nutrition assessment did not follow State Office protocol, but rather stated: "In my professional opinion, [Individual] would need the above supports for community placement." This did not provide an opinion about whether the individual could be supported in a less restrictive environment. The medical assessment stated: "Based upon the identified needed supports/services in the area of Urology, neurology for his seizures and Nursing and Medical, I believe that these supports and services cannot be provided in a less restrictive setting." However, the physician did not identify specifically what about these routine specialty medical services could not be provided in a community setting. Similarly, the nursing assessment concluded that: "Based upon the identified needed supports/services in the area of Nursing, I believe that these supports and services cannot be provided in a less restrictive setting. [Individual] requires 24-hour nursing care to maintain optimal health. In my professional opinion, I feel that [Individual] cannot be served in a less restrictive setting. He is at high risk for aspiration, has a seizure disorder, requires assistance and supervision with meals, is fully dependent on [direct support professionals] for transfers and repositioning, etc." This identified the individual's needs, but did not identify which supports the assessor believed specifically could not be provided in a community setting.	

#	Provision	Assessment of Status	Compliance
		o Disagreements in professionals' opinions about the appropriateness of community transition were noted in either the ISP meeting or the assessments for both individuals (100%). For neither of these individuals, the professionals on the team offered one joint recommendation to the individual and guardian. For example: ▪ Although the team members' assessments indicated disagreement about whether or not Individual #258 could be supported in a less restrictive setting, these were not discussed during the ISP meeting the Monitoring Team observed. An independent recommendation was not made, but rather the QDDP asked the team the question: "Are we making a referral?" to which the team responded: "No." ▪ At the ISP meeting, the Monitoring Team observed for Individual #140, the QDDP summarized that the assessments indicated he could be supported in a less restrictive setting. However, during the meeting, the nurse said that due to his autism, his needs could not be met in the community. The Admissions Placement Coordinator stated that it would be up to psychology to address his needs related to autism. The SLP indicated it would need to be a "sheltered setting" with lots of supports to make is a "good day." Other team members agreed with this, and the Admissions Placement Coordinator indicated careful planning would need to occur. The team did not make a formal recommendation independent of the LAR. ▪ 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 some limited progress in this regard, but work was still needed to ensure teams were identifying the underlying reasons for the obstacles, and developing individualized action plans to address them. LBSSLC had made some limited in this area. Using the revised ISP Meeting Guide template, it appeared that teams were discussing individuals' living options and some of the potential obstacles. However, they were not making independent recommendations to individuals and their guardians, and were not consistently documenting the resolution of discrepancies between various team members' recommendations and/or adequately justifying their decisions. In addition, more work was needed to develop appropriate action plans to addresses identified obstacles to individuals' transition to the most integrated setting appropriate. The Facility remained out of compliance with this provision.	

#	Provision	Assessment of Status	Compliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses 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. DADS Draft Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the Monitoring Team's previous reports, teams were making efforts to identify individuals' preferences. At the two ISP meetings the Monitoring Team observed and in reviewing the related documentation, team generally included some 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 at both of the ISPs observed, teams included a listing of individuals' preferences, only one of the individuals' teams (50%) had effectively incorporated their preferences and strengths into related action plans. More	Noncompliance

#	Provision	Assessment of Status	Compliance
		specifically, Individual #258's team did not incorporate his preferences and strengths into action plans. However, Individual #140's team did. For example, his preference and strength for knowing his schedule ahead of time was incorporated into a few action plans (e.g., obtaining a water safety assessment and visits to community homes), and the team used his preference for basketball to as part of a skill acquisition program to try to increase his interaction with peers. ▪ Based on the limited observation of ISP meetings and review of related documentation, teams had made some efforts to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. (i.e., for Individual #140). However, many of the preferences identified for individuals related to items, food, or activities. As noted in the past, it will be important for teams to expand these lists as well as 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. <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 two ISP meetings observed and related documents reviewed (0%) were priorities clearly defined. Although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs (e.g., in the PSI for Individual #258) or the timeliness with which specific services could be provided (e.g., dental services under general anesthesia for Individual #258), careful delineation of barriers to addressing needs was generally not found. More specifically, in none of the two ISP meetings observed (0%) were barriers identified and addressed, even when they appeared to exist. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on observation of the two ISP meetings and review of relevant documentation: ▪ One of the two ISPs (50%) (i.e., Individual #140's team discussed increasing his relationships with peers through social events such as going out to eat in the community) included specific skill acquisition action plans for implementation in the community. ▪ One of the two individuals' ISPs (50%) (i.e., Individual #140's team defined a measurable objective of going into the community with peers three to four times a week) included at least one measurable objective for general community participation.	

#	Provision	Assessment of Status	Compliance
		Although progress had been made, because some teams appeared to be talking more about individuals' preferences and strengths, as well as community activities, including sometimes community skill acquisition goals, further refinement of these discussions was needed. This included, but was not limited to expanding the scope and types of preferences and strengths the teams identified, and better incorporating them into the ISP action plans and using them creatively to expand individuals' opportunities or address their needs; clearly identifying and documenting barriers to the provision of supports and services; ensuring teams defined the frequency with which community-based skill acquisition plans would be implemented in the community; and increasing individuals' opportunities for community integration through the inclusion of measurable and meaningful objectives in their ISPs. 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;	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, and this remained an area where considerable work was needed. According to Facility staff, State Office recognized this need as well, and a workgroup had been set up to provide more guidance regarding action plan development. Based on the Monitoring Team's observations of two ISP meetings and review of the related documentation, some improvement was seen in the scope of teams' discussion of these action plans, as well as teams' review of specific goals and objectives, as well as specific action steps. These were positive developments. The following summarizes some of the positives as well as concerns related to the action plans teams discussed for Individual #140 and Individual #258: ▪ For both individuals, teams discussed action plans for each of the groupings of risk for which the individual was deemed to be at high or medium risk. This was positive and an improvement from ISP meetings and documents previously reviewed. Although such action plans remained inadequate, some progress had been made. For example: o For Individual #140, in some cases, the team discussed measurable objectives that would assist in maintaining the individual's health and providing the team with notice to intervene, such as requiring nursing to notify the PCP of a 10-pound weight increase or loss. o For Individual #258, some of the objectives the team discussed were measurable and individualized. For example, for Individual #258, an objective was developed for his oxygen saturation rates to remain at	Noncompliance

#	Provision	Assessment of Status	Compliance
		92% or above. o The team for Individual #258 included in action plans a number of specific steps that direct support professionals would take. For example, their roles were defined with regard to the completion of trigger sheets and other data collection tools, and the training that clinical staff needed to provide direct support professionals also was identified. In addition, some specific preventative supports were detailed, such as the specific amount of fluid that direct support professionals would offer him each shift, and the team specified the documentation would be completed on the food and fluid sheet. Weekly monitoring of fluid refusals was assigned to the nurse. ▪ Neither of the two teams (0%) discussed 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. For example: o When such supports were identified in the action plans they often were not measurable. For example: ▪ In developing action plans, the team for Individual #258 did consistently not identify measurable objectives, and/or objectives that assisted the team to determine if he was doing better or worse, or remaining the same. For example, the team agreed to objectives or outcomes that used terms such as "reduced incidents of…" for measuring success with the PNMP without defining any baseline by which to measure a reduction. Similarly, when discussing an objective for the action plan related to polypharmacy, the team struggled unsuccessfully to draft a measurable objective. ▪ The team struggled with the development of measurable objectives for Individual #140's Integrated Health Care Plans. For example, no measurable objective was stated for his dental action plan. Similarly, in discussing action plans, the team used terms such as "encourage physical exercise," which was not measurable. o Again, although the scope of the action plans teams discussed had improved since previous reviews, at times, necessary objectives, supports, and services were not included in action plans. For example: ▪ The team spent little time discussing supports that would assist Individual #258 to have a more meaningful day and to become more independent. Although some assessments and the PSI indicated a need to involve Individual #258 if off-home day	

#	Provision	Assessment of Status	Compliance
		programming, the team did not develop an action plan and/or measurable objectives to ensure this occurred. ▪ Although it was positive that Individual #140's team recognized the need for psychology and psychiatric staff to establish measurable objective(s) related to psychiatric symptoms, it was concerning that an adequate objective(s) was not already in place, particularly given that the individual was prescribed psychotropic polypharmacy. In its response to the draft report, the State/Facility indicated: "in the PBSP JJ1645F for individual #140 implemented 01/18/2012 and revised 05/02/2012, aggression is denoted as the marker behavior for Seroquel, Depakote, and Clonidine, with a medication plan delineating planned changes based on the individual's behavioral response. The PBSP includes a measurable objective for aggression." As discussed with regard to Sections J.10 and J.11, Individual #140's polypharmacy was not justified, and more refined data was needed to allow the team and guardian to make decisions regarding the medications. Given that the individual's diagnosis was autism, and the team's extensive discussion at the ISP meeting about the impact of some environmental modifications (i.e., giving Individual #140 new options for communication) on the aggressive behavior, the Monitoring Team continued to be concerned. Similarly, although the team approved Individual #140's PBSP, with some changes, the team did not discuss a specific action plan, including measurable objectives for target and replacement behaviors. ▪ The action plans teams' developed to address individuals' risk areas generally did not include adequate measurable clinical indicators. 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. Although it was clear the teams observed were trying to improve in this area, further work was needed to assist teams in identifying adequate, measurable 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). In addition, teams should identify parameters for when direct support professionals or nurses need to contact the nurse or the PCP, respectively, and/or the team needs to meet to ensure changes in status are adequately addressed. ▪ 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	

#	Provision	Assessment of Status	Compliance
		moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, significant work was needed to individualize action plans to overcome obstacles to community transition, and ensure they are measurable. Based on observations of two ISP meetings on site, it appeared some progress had been made in the expansion of the scope of measurable objectives, and efforts were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which work was needed. 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;	Since the last review, some action had been taken to improve the comprehensiveness of ISPs. Specifically, after Staff Office consultants provided training, two teams at LBSSLC had begun piloting a new ISP Meeting Guide (Preparation/Facilitation/Documentation Tool), along with a new process for completing the IRRF and developing integrated health care plans. This process was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed individuals' array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. Limited observation of two ISP meetings and review of the related documentation showed that teams were talking more about the various "protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual." The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs. As the Monitoring Team's observations of two ISPs meeting on site indicated, the majority of the time was spent on the risk rating process and discussion about action steps that would be included in the integrated health care plans. Although these were essential activities in which teams needed to engage, it resulted in limited time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics, such as the individual's vocational ambitions and plans to achieve them, his/her plans to increase skills leading to greater independence, ways in which greater integration into the community could occur, etc. Additional preparation by the QDDPs as well as other team members before the meetings was an area for improvement. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could	Noncompliance

#	Provision	Assessment of Status	Compliance
		have discussed any questions and then made decisions. Another consideration would be the development of draft action plans prior to the ISP meeting. This would seem to be a reasonable and necessary process to allow the meeting time to be shortened and adequate time to be spent on other important topics. However, the major caution relates to the concern that this would result in less collaboration between disciplines and the "silo" effect of team members coming to the table with predetermined plans. If action plans were to be drafted ahead of time, QDDPs would need to make clear that they were drafts, and the expectation would need to be set that changes to the drafts would be the norm as opposed to the exception. Again to reduce meeting time, an expectation might also be set that team members review them ahead of time, and come to meetings with mark-ups and/or questions. Neither of the two teams observed (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 consistently and comprehensively address the plans in a way that showed integration was occurring. The following provides examples of some of the positives that were seen as well as some of the problematic areas: ▪ More inclusion was seen into the ISPs of the medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care/health management plans, but in some cases, concerns were still noted. Positive examples included: o The ISP meeting for Individual #140 showed good integration between psychology, speech and language therapy, as well as vocational. Working together, they had identified some supports to assist Individual #140 with his communication, including both receptive and expressive skills. In turn, this had had a positive impact on his behavior. o In discussing risk areas, the team made recommendations for changes to Individual #258's PNMP. These changes were confirmed during the meeting, and the team approved the "revised" PNMP. o For Individual #258 and Individual #140, based on the teams' discussion of the Integrated Health Care Plans, they were inclusive of multiple disciplines, including nursing, medical, and habilitation therapy staff, as well as direct support professionals, and psychology and psychiatry, as appropriates. Examples of concerns included: o Although the team for Individual #140 had some discussion about potentially reducing the polypharmacy for psychotropic medication, little to no discussion occurred regarding the risks versus the benefits of the medication, the justification for the polypharmacy, and/or the	

#	Provision	Assessment of Status	Compliance
		alternatives to medication. No data was presented regarding the specific psychiatric symptoms that were being monitored. It was positive that the team agreed that the psychologist and psychiatrist would collaborate on a measurable objective related to psychiatric symptoms, but it was concerning that such an objective was not already in place. o Staff from the dental office were not present at the ISP meeting for Individual #258, so this limited the discussion of dental supports. However, the team identified him as being at high risk, and, in writing, the dentist had recommended that Individual #258 undergo dental procedures under general anesthesia. The reason stated was that Individual #258 had missed three dental appointments. However, it appeared that this was due to his being hospitalized at the time of two appointments, and not having maintained "nothing by mouth" status for one. Although the team did not discuss the previous appointments, it was unclear why other appointments with the dental clinic were not scheduled. The dentist indicated that aspiration risk was one reason for the recommendation for general anesthesia, but it was unclear if coordination and advice had been sought from Habilitation Therapies. In addition, the waiting list for general anesthesia was a year. The team should have identified this as a "barrier" to meeting one of his needs, but they did not. Although the team recognized the need to inquire further with the dentist, at the time of his ISP an adequate dental treatment plan was not integrated into the ISP. o Similarly, for Individual #258, the team did not discuss his day program options in any detail. Given his medical and therapeutic needs, this should have been an integrated discussion that involved many team members. ▪ The new format of the ISP included a column for staff responsible for implementation/documentation of plans, as well as one for those responsible for development of the plan, and person(s) responsible for reviewing progress and effectiveness. These were positive additions. Although this was not consistent for all of the action plans the two teams created, based on the Monitoring Team's observations, this was generating more relevant discussion. For example: o Based on observation of the ISP meeting, although work on this was still needed, some of the IHCPs for Individual #140 included good definition of which team members were responsible for what. For example, the action plan for constipation included the preventative measure of Individual #140 drinking three liters of fluid. Direct support professionals were identified as responsible for documenting his intake of three liters of fluid, and nursing staff were identified as responsible	

#	Provision	Assessment of Status	Compliance
		for monitoring the documentation. A list of signs and symptoms of constipation also were identified for direct support professionals to monitor, and report to nursing. Nursing was then responsible for training of staff and assessment of Individual #140 should such signs be identified. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, it was in its initial stages of implementation. Some limited improvements were seen. However, teams will need additional coaching and mentoring to fully implement the process and develop ISPs that meet this requirement of the Settlement Agreement.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Based on observations of two ISP meetings, when developing action plans, teams often discussed the staff responsible, and the timeframes for completion. At times, teams appeared to be confused about timeframes. In part, this seemed to be due to the previous practice of identifying completion dates as "ongoing" or "as needed." Some team members had trouble quantifying the timeframes and/or frequency with which tasks would be completed. 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. Although methods for implementation sometimes were discussed, teams were not consistent. For example, when discussing the need for Individual #140 to exercise regularly, due to his weight and risk factors for metabolic syndrome, the team indicated staff would "encourage" him to exercise. This was not an adequately defined methodology. Similarly, for many of the integrated health care plans for Individual #258 and Individual #140, the nurse case managers and the teams should have referenced and individualized State Office nursing protocols to better define the methods for nursing interventions, but they did not. As a result, adequate methodologies were not developed. As noted above, based on the ISP meetings observed, 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. An 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. Of note, the teams discussed some of the roles and responsibilities of clinical staff in the training of staff, monitoring and updating of programs, and review and revision of	Noncompliance

#	Provision	Assessment of Status	Compliance
		programs. This was a positive improvement, and concerted efforts will be needed to ensure this occurs consistently. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and specific team members should be identified as responsible.	
	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 two plans developed during the week of the Monitoring Team's review (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. An area in which some improvements were seen was in developing supports and services that were practical and functional in the community. Although as discussed below, this remained an area of concern, it was positive to see teams making efforts to identify skill acquisition programs that made sense for the individual, addressed an outstanding need, and assisted the individual to function more independently. At both of ISPs the Monitoring Team observed, teams identified a mix of functional and nonfunctional objectives. For example: ▪ Although the team for Individual #258 tried to identify more functional objectives, some were (e.g., using hand sanitizer), while others were not (e.g., responding to his environment for which the team did not come up with specific responses or interactions). ▪ Some of Individual #140's action plans/objectives were functional (e.g., maintaining his own communication book, building stronger relationships with peers through basketball and eating out, and obtaining and learning to use an IPad to assist with communication), but others were not (e.g., it was unclear what the function was of his identifying his medication box, or how this would assist him with community living). 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. Individual #140 had learned to walk to the cashier's office to obtain his pay. This could be a difficult practice to transition to the community, if a bank with a teller is not within walking distance. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Similarly, individuals generally did not have objectives related to housekeeping or yard	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 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.	
	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.	Based on Monitoring Team's observation of the two ISP meetings, for some action plans, the teams discussed specifically what data would be collected, how often data would be collected, who would collect the data, and who would review it. However, review of the full plans would be necessary to determine the extent of the teams' adherence to this requirement. Some positive examples included: ▪ The team for Individual #258 included in some of the action plans the data that direct support professionals would collect. For example, their roles were defined with regard to the completion of trigger sheets and other data collection tools. In addition, some specific preventative supports were detailed, such as the specific amount of fluid that direct support professionals would offer him each shift, and the team specified the staff would document on the food and fluid sheet. Weekly monitoring of fluid refusals was assigned to the nurse. However, in many other instances, the teams did not define data collection methodologies or frequency of data collection. At the time of the review, neither of the two ISP meetings the Monitoring Team observed (0%) appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Since the last review, improvement was seen with regard to data being used to inform some of the at-risk discussions, although this was an area that still required improvement. Additional data that should have been included, but was not, related to skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, psychiatric treatment plans, etc.), and details regarding individuals' successes or failures, etc. As is discussed below with regard to Sections K and S of the Settlement Agreement	Noncompliance

#	Provision	Assessment of Status	Compliance
		processes were not yet adequately implemented to determine the reliability of the data, but efforts were underway in this regard. However, there continued to be some indications that the data being collected was not reliable. Although LBSSLC was making progress by using the new State Office ISP template, teams needed to continue to work on clearly identifying the data to be collected or documentation to be maintained, the frequency of data collection, the person responsible for data collection, and the person responsible for data review. Teams needed to use such data consistently to conduct objective analyses of individuals' progress.	
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 previous reports, and based on the current review of ISPs, this was an area that required 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. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	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 Draft Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to staff who must implement it. At the time of the review, the ISPs were located on the residential units, but locked in cabinets or offices 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 accessible to staff. Due to the limited review of ISP meetings the State agreed to, the Monitoring Team cannot comment on manner in which plans were written, and whether or not they facilitated direct support professionals' understanding. In previous reports, an issue related to comprehensibility of ISPs was the lack of delineation of responsibility for the implementation of the plans. For a direct support professional, the ISPs were not written to allow easy determination of 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. During this most recent review, observations of ISP meetings showed that teams were trying to correct some of these	Noncompliance

#	Provision	Assessment of Status	Compliance
		issues. More discussion than in the past occurred about specifically what the responsibilities were of direct support professionals, as well as other team members. Although it was very early in the new ISP process, this was encouraging to see, and, hopefully will result in plans that are more understandable to those that need to implement them. As noted above, continuing work also was needed on defining the methodologies. In addition, implementation of the new ISP process had begun to pull together the previously many separate plans and integrate them 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. In doing this, staff should be able to reference 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. This document also should point team members to the more detailed plans that the team has approved.	
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 Draft Policy #004 at III.A addressed personal support plan monitoring. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. Since the last review, a new 30-day Active Record Review – QDDP Integrated Progress Note (IPN) template had been piloted with four QDDPs. The Facility provided a copy of the template. In addition, the Monitoring Team reviewed a sample of monthly reviews completed for four individuals, including one from each of the caseloads of the four QDDPs involved in the pilot project (i.e., Individual #223, Individual #233, Individual #120, and Individual #98). Based on this review, some positive changes included: ▪ For skill acquisition programs, graphs had been embedded into the document to show data for the ISP year. Although the narrative sections of the monthly reviews in the sample showed minimal analysis of this information, this might have been due to the fact that many of the skill acquisition programs had recently been implemented. However, this provided a more objective way of reviewing the individuals' progress on the programs, and was a very positive addition to the process. ▪ Some prompts were included to remind the QDDP to review and analyze certain aspects of care and treatment, such as incident and allegation data, and medical consultations. Concerns noted were: ▪ The format included a section for "Review of Risk." However, it only summarized the most recent risk ratings for the individual. It did not prompt	Noncompliance

#	Provision	Assessment of Status	Compliance
		the QDDP to review implementation and/or progress on the related action plans to determine if changes were needed or the team needed to meet. As a result, in the sample of individuals reviewed, all of them had medium-risk ratings, and three of the four had multiple high-risk ratings as well. The monthly summaries provided no review of the status of the related action plans. ▪ Similarly, although the template prompted review of certain types of services and supports, such as PNMT involvement, supported employment, and counseling services, it was not clear what the QDDPs' role was in reviewing the integrated progress notes from other team members responsible for oversight of specific action plans to determine if action was needed and/or the team needed to meet. For none of the four individuals reviewed, the monthly reviews commented on review of other team members' integrated progress notes. Based on the Monitoring Team's review that was limited to a sample of monthly ISP reviews completed using the new format: ▪ For the sample of four individuals, nine monthly reviews were submitted in the new format. For two of these individuals (50%), the monthly reviews had been completed timely. For Individual #233 and Individual #120, some of the monthly reviews had been completed months after the review period ended. ▪ For none of the nine monthly reviews completed (0%), the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. ▪ For none of the nine monthly reviews, a lack of expected progress was noted requiring action. However, as noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if problems existed that should have been addressed. At the time of the review, it remained unclear how the Facility would meet 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 and at-risk individuals. Although some progress had been made in integrating skill acquisition data into the	

#	Provision	Assessment of Status	Compliance
		QDDPs' monthly review, the Facility did not yet have an adequate monthly review process in place. The Facility remained out of compliance with this provision.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	The following provides an update on the training related to the ISP process that had been provided to staff as of the time of the review: ▪ As reported in previous reports, training on ISPs had been standardized across the SSLCs. However, since the Monitoring Team's last review, this training had been modified. Based on interview with staff from the QDDP Department, the new Supporting Visions: Person-Centered Planning, dated 9/2012, would be used during new staff orientation. Based on review of the PowerPoint presentation and related Workbook, the training appeared to provide an overview of the planning process, and the roles of the various team members. It also set forth DADS Leadership's expectations with regard to person-centered planning. A role-playing exercise required participants to take on the role of a particular team member. Participants were assessed on their role-play, and also took a written test. Because the full curriculum was not provided, the Monitoring Team did not review the full content of the training or the role-play scenario. The Monitoring Team will request the full training materials during an upcoming review. ▪ As noted with regard to Section F.1.a, in August 2012, the State Office provided additional training on a revised ISP format and process to QDDPs and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/ Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, the new process on which the QDDPs were trained included more pre-planning that began 90 days prior to the ISP meeting. As part of this, QDDPs were trained on the implementation of a new tool/assessment entitled the Preferences and Skills Inventory, as well as the new ISP Preparation Meeting process. Written instructions for the ISP meeting guide also were provided to QDDPs. These instructions provided some helpful hints and direction to QDDPs. ▪ In addition, as discussed in detail with regard to Section I, QDDPs and team members had been provided training on the revised Integrated Risk Rating Form and Integrated Health Care Plan forms and processes. ▪ On various dates in September 2012, in addition to the QDDP Coordinator and QDDP Educator, a number of department heads and the Facility Administration had attended training at the State Office on the new ISP process, including the IRRF and IHCP processes. Reportedly, the training had helped to clarify roles and responsibilities, and emphasized the importance of full team participation in the ISP process. ▪ As new QDDPs were hired, they participated in the initial "Q Construction: Facilitating for Success" training. This training included a written test that each	Noncompliance

#	Provision	Assessment of Status	Compliance
		participant completed at the end of the classroom training. It also included a competency checklist. The competency checklist generally provided a good format for reviewing a number of planning and facilitation skills. As is discussed further below, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. However, as noted in previous reports, its implementation provided some valuable information to assist QDDPs in refining their skills. ▪ As noted in the previous report, of significant note was the development and implementation of an On-the-Job training process for new QDDPs. This involved a number of different meetings, observations, review and training on specific processes and requirements, completion of specific processes, and records reviews. It was conducted over a four-week period of time. For each week, a detailed schedule had been developed. In addition to spending time with the QDDP Educator, 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 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. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As noted above, on 8/21/12 and 8/22/12, QDDPs and other team members, had undergone additional training on the revised ISP format and process. A State Office consultant provided this training. When asked what the expectation was moving forward for training new staff on the revised process, Facility staff indicated this would be the responsibility of the QDDP Educator. Although the QDDP Educator had attended the training in August, as well as supplemental training in September in Austin, it was not clear whether a process was in place to ensure QDDP Educators had been deemed competent to provide the training that State Office consultants had been responsible to provide. ▪ 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, the Facility had been using a tool to test the facilitation component of competency-based training. At the time of the review, based on a list dated 5/24/11 (although this appeared to be an error), the Facility reported that six of the 14 QDDPs had successfully completed the competency check-off. However, this process was about to change. According to staff, State Office had developed the ISP Monitoring Checklist. This would have a dual role of monitoring, as well as assessing QDDPs' facilitation	

#	Provision	Assessment of Status	Compliance
		skills. At the time of the review, the new tool was being finalized, and was expected to be available for use later in October 2012. ▪ The Facility had not yet begun to implement competency-based measures for the writing of ISPs. ▪ 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, there should be additional training 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, and Facility staff indicated continued to be a need. ▪ As is discussed in further detail with regard to Section S of the Settlement Agreement, additional training on the development of skill acquisition programs continued to be an area of need. ▪ 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 should be developed and implemented for the development of the ISP documents, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete 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	In its pre-review request, the Monitoring Team asked for: "Over the last one-year period, a) the total number of ISP annual meetings that occurred more than 365 days after the previous annual meeting; and b) the total number of ISPs that were filed more than 30 days after the annual ISP meeting was held." The Facility did not provide the total numbers as requested. Although the Facility did provide raw data in response to this request, it appeared to be data since the last review, as opposed to over the one-year period the Monitoring Team requested. The following findings are based on the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Monitoring Team's analysis of the raw data. Since the Monitoring Team's previous review, three individuals had been admitted to the Facility (i.e., Individual #27, Individual #30, and Individual #40). For all three individuals (100%), initial ISP meetings had been held within 30 days of admission. Based on data the Facility provided, between 3/1/12 and 9/21/12, annual ISP meetings were held for 119 individuals. Of these 110 (92%) occurred within the 365-day timeline. The range of days beyond 365 was from one to 50, with an average of 14. In its Presentation Book, the Facility provided copies of the Facility Director's approval of ISP meetings held past the deadline for two individuals. In one case, the individual was hospitalized at the time his ISP meeting was due, and another delay was in response to a guardian's request. Both of these were legitimate reasons for the meetings occurring late. For the remaining individuals, the Facility did not provide and the Monitoring Team did not request the Facility Director's approval, so the reasons were not known. The Facility tracked the dates that ISPs were filed in the records. For the time period between 3/1/12 and 8/31/12, 22 of the 110 plans (20%) were filed within 30 days of the ISP meeting. The days beyond 30 ranged from 1 to 169, with an average of 47. As noted above with regard to Section F.1.a, the Facility had begun to provide a "Ghost" QDDP the day following an ISP meeting to allow the QDDP that had facilitated the meeting the day before to write-up the ISP. With very limited interruptions, this appeared to be having a positive effect on QDDPs' ability to turn-around the ISP documents quickly and accurately, so that implementation could begin. Of note, the Facility had graphed the data it had collected in relation to filing ISPs within 30 days of the meeting. It showed improvement in the month of August 2012 and for the data collected thus far for September 2012. 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 remained out of compliance with this provision. However, some progress was noted, and Facility staff were actively pursuing potential solutions to completing the ISP documents within 30 days of the ISP meetings.	
F2g	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	developed consistent with this section of the Settlement Agreement. Positive developments included: ▪ DADS Draft Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ As noted in the previous report, 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. ▪ Based on documentation and interview, one corrective action plan was being implemented with regard to the ISP process or documents. It related to a key performance indicator that read: "Each individual's appropriate and functional living environment will be identified ensuring they live in their most integrated setting with needed supports and services." This was an important goal. However, it was unclear how some of the action steps included in the related plan would achieve the desired goal. Many of them were important in and of themselves, but it was unclear if data identified through monitoring had been used to inform to decisions to implement this plan and/or any of the action steps within it. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ In its last report, the Monitoring Team indicated that the Facility had made a 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. However, at the time of the October 2012 review, no revised instructions for the monitoring tools were available. This was understandable given the change in leadership in the QDDP Department, and other priorities. However, this is an important task that should be completed. Adequate instructions will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ For the monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff responsible for conducting audits. This had been understandably delayed due to the change in QDDP Coordinators. As noted above, the QDDP Coordinator's monitoring responsibilities had been put on hold, so no comparison could be made with the findings of the QA Department's	

#	Provision	Assessment of Status	Compliance
		Program Compliance Monitor. ▪ The Facility's analysis of the data continued to be at the beginning stages. On a quarterly basis, the QA Department analyzed the cumulative data, and reports were provided to the QA/QI Committee. However, QA/QI Quarterly Summaries, dated 5/10/12 and 8/13/12, showed little analysis of the data. The QA/QI Committee made decisions about the need for formal corrective action plans to be developed and implemented. As noted above, the Facility was implementing one corrective action plan related to the ISP process. However, 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: "At this time there are not any actions taken or corrective action plans in regard to monitoring/audited data that the Facility has collected in relation to integrated protections, services, treatments, and supports." Given that the corrective action plan mentioned above was initiated on 6/7/12, it was unclear why the Facility provided this response. 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 draft criteria for determining when a team member's attendance at an ISP meeting is required should be finalized, and incorporated into the attendance database to ensure its reliability. As previously recommended, such criteria should take into consideration the Settlement Agreement requirement that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." (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' ISPs. This should include ensuring that, as appropriate, assessments consistently and concisely identify individuals' strengths, needs, and preferences. (Section F.1.c)
4. The Facility/State should finalize 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. The ISP Preparation Meeting documentation should include a justification, particularly when they are not requiring completion of an assessment for which the individual has specific needs.

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.1.c)

5. Assessments should include a full set of recommendations that are designed to assist the teams in developing action plans that describe the array of protections, supports and services that the individual requires. As appropriate, assessments should recommend specific areas of focus for skill acquisition programs, as well as detail data that needs to be collected and roles and responsibilities of various staff. (Section F.1.c)
6. Now that the ISP process includes an annual review of incidents, and abuse, neglect, and exploitation allegations, teams should adequately address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
7. 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)
8. 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)
9. 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)
10. The Facility should address barriers such as transportation, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups. Individuals' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
11. 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)
12. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. 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)
13. 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)
14. 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)
15. 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)
16. ISPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
17. 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)
18. 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.;
c. QDDPs should document their review and analysis of other team members' monthly reviews; and
d. QDDPs should document clearly follow-up activity and/or changes that are made to ISPs. (Section F.2.d)

19. 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)
20. 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)
21. 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)
22. Consideration should be given to adding examples of ISPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QDDPs and teams what is expected. (Section F.2.e)
23. IDTs should complete additional training and/or be provided technical assistance 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. (Section F.2.e)
24. 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. (Section F.2.f)
25. 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.2.g and Facility Self-Assessment)
26. 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)
27. As the Facility expands its self-assessment activities, the Self-Assessment should indicate how the Facility has used its data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section G; o For provider morning meeting minutes, copies of all minutes, handouts, hospitalizations, and 24-hour reports discussed, for following dates: 7/2/12, 7/9/12 to 7/13/12, 7/16/12, 7/19/12, 7/20/12, 7/23/12 to 7/27/12, 7/31/12, 8/17/12, 8/20/12, 8/21/12, 8/23/12, 8/24/12, 8/28/12 to 8/31/12, 9/4/12, and 9/5/12; o For hospitalizations in prior six months, follow-up ISPAs for the following individuals: Individual #323, Individual #312, Individual #250, Individual #226, Individual #293, Individual #299, Individual #12, Individual #193, Individual #281, Individual #74, Individual #306, Individual #61, Individual #176, Individual #113, Individual #68, Individual #104, Individual #9, Individual #167, Individual #196, Individual #239, Individual #280, Individual #112, Individual #139, Individual #25, Individual #324, Individual #214, Individual #33, Individual #197, Individual #29, Individual #2, Individual #78, and Individual #90; and o For one individual from each residential home, all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPNs) commenting on consultant reports (i.e., medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISP addendum related to the consultant report, including: Individual #154 for endocrinology 3/29/12, podiatry 4/18/12, sleep study 4/19/12, vision clinic 6/14/12, podiatry 6/20/12, and podiatry 7/18/12; Individual #136 for endocrinology 7/5/12, gastroenterology 7/17/12, vision clinic 5/4/12, neurology 6/6/12, and pulmonology 8/6/12; Individual #15 for vision clinic 7/6/12, oncology 7/18/12, oncology 6/13/12, PET scan report 5/30/12, oncology 7/11/12, oncology 5/16/12, oncology 4/18/12, and oncology 3/21/12; Individual #164 for neurology 7/11/12; Individual #322 for neurology 5/9/12; Individual #161 for neurology 4/4/12, endocrinology 4/26/12, sleep study 5/1/12, neurology 5/11/12, podiatry 5/23/12, and CPAP study 5/31/12; Individual #170 for neurology 3/7/12, and gastroenterology 5/21/12; Individual #125 for urology 3/22/12, endocrinology 3/29/12, podiatry 5/23/12, neurology 6/22/12, and neurology 7/25/12; Individual #112 for neurology 3/7/12, cardiology 3/13/12, and neurology 5/9/12; Individual #182 for neurology 4/4/12, vision clinic 5/4/12, neurology 5/9/12, and neurology 7/25/12; Individual #62 for endocrinology 3/29/12, urology 4/2/12, and neurology 5/9/12; Individual #223 for podiatry 4/18/12, gastroenterology 7/6/12, and gastroenterology 8/10/12; Individual #274 for vision clinic 5/4/12, neurology 4/4/12, and endocrinology 7/5/12; Individual #128 for gynecology 4/18/12, neurology 4/25/12, sleep study 7/2/12, urology 7/20/12, and gynecology 8/2/12; and Individual #156 for neurology 3/23/12. ▪ **Interviews with**:

	o Glenn Shipley, DO, MPH, and o Leah Shults, RN, BSN, Medical Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The Facility monitored provider meeting minutes to determine closure rates for concerns identified at the morning meeting, audited morning provider meeting minutes to determine documentation of consultation report review and recommendations, audited consultation reports to verify information recorded in medical database and to determine timeliness of PCP response with agreement or no agreement, conducted external and internal medical peer review, including general medical audits and medical management audits of specific diagnoses. o These monitoring/audit tools included a number of areas important to determine compliance with the Settlement Agreement. However, given the scope of integrated clinical services, the audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, there are many aspects of the provider morning reports at LBSSLC that would provide evidence of progress toward compliance, and these aspects should be measured. o The monitoring tools included adequate methodologies, such as record reviews, review of consult reports, reviews of provider morning meeting minutes, review of ISPAs, etc. o In a number of instances, the Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For instance, the total number of meeting minutes was identified in creating a sample to review the documentation related to consultant recommendations in these meetings. The total number of consultation reports was identified, from which a sample was obtained for further review. The sample sizes (13.5% in the documentation of recommendations in the minutes, and 9% for PCP processing of consultation reports) appeared to be an adequate number from which to determine a baseline for future trend analysis. However, given the results of the Monitoring Team's audit differed from the department audit, although the reason was not identified, the Monitoring Team's sample size of consultant reports was selected using a different methodology and the number of reports was much greater. o The following staff/positions were responsible for completing the audit tools: The external and internal medical peer reviews are described in Section L. For the other internal audits and reviews, the Medical Compliance Nurse completed the reviews. There were no personnel from the QA Department to confirm the findings or provide a second set of data for inter-rater reliability.

	○ The staff responsible for conducting the audits/monitoring was clinically/ programmatically competent in the relevant area(s). ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. These included information about the provider morning meeting closure rates, attendance tracking of all clinical disciplines at the provider morning meeting, Emergency Room (ER) and Hospitalizations Quarterly Trend and Analysis, ISPA Tracking Log, Consultant's Recommendation Tracking Report, and the Medical Database Tracking System. Tracking of PNMT recommendations through to PCP orders was a data source currently being developed. The quality of the data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources that were not considered included follow-up completion of PNMT recommendations; tracking open record reviews of individuals hospitalized or sent to the ER to determine early warning signs or symptoms, and initiate earlier assessments and interventions; and tracking the quality of the ISPA to determine if they met the concerns discussed at the morning provider meeting. ▪ The Facility consistently presented some of the data in meaningful/useful ways, but some improvements were necessary. Specifically, the Facility's Self-Assessment for Section G: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. For instance, the Facility's Self-Assessment did not comment on the quality of the ISPAs submitted in response to the morning provider meeting requests. ○ Did not distinguish data collected by the QA Department versus the program/discipline. However, it appeared that the Medical Department provided all monitoring activity. ○ The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings. ○ The Facility data identified areas of need/improvement, and there was documentation of Medical Department discussion of the information resulting from the audits and monitoring data. For some of the areas of need, the Facility Self-Assessment provided an analysis of the information. For example, in relation to the data pertaining to hospitalizations, the Facility identified the need for in-service education to the direct support professionals on dehydration. The data collected was followed by interpretation and application through teaching, etc., in order to improve clinical care at LBSSLC. However, as mentioned, the Medical Department should expand the areas of medical care being monitored to ensure the processes in place are effectively working and creating an environment of quality care.
	Summary of Monitor's Assessment: The provider morning meeting was an interdisciplinary forum at which many areas of clinical care were reviewed (i.e., acute care, hospital care, consults, lab data, and diagnostic reports). It also was a forum to share clinical topics of importance, often in the context of providing training and education (e.g., on hospital and ER trends, Reclast protocol, etc.).

	To provide a baseline of evidence for integrated clinical care, each department's attendance at the provider morning meeting was tracked. Additionally, a system had been created to assign concerns identified at the provider morning meeting to a member at the meeting, or to the IDT. These concerns were tracked to closure, and often required written documentation. The morning provider meeting team also provided guidance to the IDT on the concern that needed to be addressed usually by putting it into the context of a challenge identified with regard to the care of an individual. The QDDP Educator attended this meeting and provided guidance to the QDDPs in addressing the concerns through the IDTs. Other departments reported periodically to this committee as other evidence of integrated clinical care, such as the skin integrity committee, the laboratory technician, and the PNMT. To ensure consultant recommendations were integrated into clinical care, the Medical Department tracked the PCPs' review of these reports, as well as the timeliness of the review. Documentation of the PCP's agreement or not concerning the recommendation also was tracked. The challenge in demonstrating integrated clinical care was several-fold. Maintaining the efficiency and breadth of the provider morning meeting to demonstrate sustainability will be important. From the Monitoring Team's review, the IDTs needed continued guidance and accountability, and an expansion of open record reviews to determine early signs and symptoms helpful in treating illness at an early stage. Documentation of interaction between the PCP and the PNMT at PNMT meetings needed improved tracking. Interaction might include attendance at the meeting or participation through conference call. For the ISPAs that were the written response to a concern assigned to the IDT, there was need to determine if the provider morning meeting participants agreed or not with the ISPA (i.e., did it satisfactorily answer the concern). As the consultant recommendations are important to integrated care, there should be a process in which the consultant reports are reviewed by the IDT. However, it was not clear if there was a well-defined system in which consult recommendations were forwarded to the IDTs, and the IDTs reviewed these and documented review and discussion in ISPAs.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The provider morning meeting was an interdisciplinary forum discussing clinical care. As evidence toward integrated clinical care, the Medical Department all departments' tracked attendance at this meeting. Data was submitted monthly for July through September 2012. From a document entitled "Daily Medical Provider Meeting," for each month, it was determined whether one or more staff from each department attended the meeting. Departments tracked included PCPs, other Medical Department staff, Dental Department, Pharmacy Department, Residential Services, Psychology, Nursing, Habilitation Services, and the QA Department. For July through September, several departments had 100% representation each business day of the month, including PCPs, other members of the Medical Department, Pharmacy, Psychology, and Nursing. For those departments with less than 100% attendance, the following were the documented attendance rates per month for each department:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Dental Department: July 2012 – 71%, August 2012 – 52%, and September 2012 – 58%. ▪ Residential Department: July 2012 – 100%, August 2012 – 87%, and September 2012 – 100%. ▪ Habilitation Services: July 2012 – 81%, August 2012 – 78%, and September 2012 -89%. ▪ QA Department: July 2012 -81%, August 2012 – 91%, and September 2012 – 95%. The provider morning meeting was documented in daily minutes. It appeared that the structure of the morning meeting expanded over the month of July 2012. Minutes of 15 days in July were submitted for review. Of these: ▪ 15 of 15 (100%) recorded attendance. ▪ 14 of 15 (93%) included a review of the Campus Coordinator log and the on-call provider report. ▪ Six of 15 included a review of various systemic aspects of medical care. These were examples of the provider morning meeting being used as a forum for interdepartmental communication and discussion. The topics included a review of the internal medical audit findings, the Reclast protocol, a review of action steps to reduce dehydration at LBSSLC, a review of positive behavior support, vitamin D supplementation dosage, timeliness of Quarterly Drug Regimen Review (QDRR) review by PCPs, provision of detailed information on consultation forms, and a review of ER and hospital data from the second quarter, followed by potential action steps. Discussion indicated an integrated approach to developing and finalizing protocols and clinical processes. For the topic of dehydration prevention, an 8/2/12 in-service concerning prevention of dehydration was held as a corrective action related to the discussion at the provider morning meeting. A one-page handout "Dehydration is an all year concern" was developed as a training document. The in-service was provided to habilitation services staff (27), QA staff (15), nursing (105), and residential staff (325). Training was completed for 472 of 481 (98%) of staff for which the in-service was appropriate. A tracheostomy dislodgment in-service was provided from 6/28/12 to 7/10/12 for 19 staff. ▪ Two of 15 included a Medical Director announcement. ▪ The Infection Control Nurse or designee provided announcements/information at eight of 15 meetings. ▪ The Hospital Liaison Nurse provided a report in seven of the 15 meetings. ▪ A PNMT report was included at three of 15 of the meetings. ▪ Medical/dental restraints were reviewed at six of 15 meetings. ▪ An update on skin integrity was reported at two of 15 meetings. ▪ 14 of 15 (93%) included a discussion of closure items that had been identified by	

#	Provision	Assessment of Status	Compliance
		the provider morning meeting. These were tracked both in the minutes and in a separate table format. Additionally, if an in-service on a topic was required in order for staff to carry out the ISPA, such as signs of bowel obstruction from pica ingestion, a training roster was required as part of the closure evidence. ▪ During these 15 provider morning meetings, five ISPAs were reviewed and 56 consultation reports were reviewed. As of the July 2, 2012 provider morning meeting, the QDDP Educator was to be a daily participant and liaison between the provider meeting and the various IDT meetings. Any follow-up requests the provider morning meeting team made (e.g., related to hospitalizations, clinic issues, consultations, requests for closure by the morning meeting, etc.) were routed through the QDDP Educator to the appropriate QDDP for IDT follow-up. The IDT then had five calendar days to meet and develop an ISPA in response to a health status change and determine any change in risk rationale based on the recommendations. These reports were to be passed through the QDDP Educator back to the Medical Compliance Nurse for review and summary discussion at the provider morning meeting. This process provided a system to integrate the clinical discussion at the provider morning meeting with the IDT discussion, and guided the IDTs in clinical follow-up. It also provided evidence-based tracking to show the progress of the system. Additionally, the minutes reflected that the QDDP Educator received an email notification of the IDT referral from the Medical Compliance Nurse regarding the concern identified at the provider morning meeting. As part of the provider morning report, a weekly skin integrity report was documented in the minutes. These reports provided important details and updates, and discussed dressing orders and consults for these individuals as indicated. The PCP provided further discussion of the cases. At the 7/26/12 morning meeting, it was recorded that the Nursing Department was developing a report/database for those with excessive weight gain or loss. This was to be brought to the committee for review. A second sample of provider morning meeting minutes was submitted. The dates were from 8/17/12 through 9/5/12. The number of meeting minutes totaled 11. The following information summarizes the contents of these 11 meetings: ▪ 11 of 11 meetings (100%) recorded attendance. ▪ 11 of 11 (100%) included discussion of the Campus Coordinator Log and the on-call provider report. ▪ One of 11 included a discussion of a corrective action (i.e., the internal and external medical peer review audit results for Round #6).	

#	Provision	Assessment of Status	Compliance
		▪ Two of 11 discussed measures to prevent another hospitalization/ER visit for two individuals. ▪ None of 11 discussed results of an open record review for a hospitalization. ▪ Two of 11 included information provided through a Medical Director announcement. ▪ Five of 11 (45%) included discussion and resolution of closure items. ▪ Four of 11 (36%) reviewed ISPAs as part of the closure process at the provider morning meeting. A total of 12 ISPAs were reviewed. ▪ The Infection Control Nurse provided a report/information at one of 11 meetings. ▪ Eight of 11 meetings reviewed consult reports, as well as whether scheduled consults were not completed. A total of 56 consults were reported or updates provided as to status of the consultation. ▪ One of 11 recorded a PNMT report. ▪ Four of 11 recorded updates concerning individuals having medical restraints. ▪ Two of 11 recorded a skin integrity report. ▪ None of 11 recorded a report of any individuals with significant weight gain or loss. The Facility submitted ISPAs for hospitalizations that occurred during the six months prior to the Monitoring Team Visit. Hospitalizations involved 32 individuals. These were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization. Of the 32 individuals, two individuals were hospitalized for concerns that did not apply to these measures and were excluded (i.e., planned surgery, etc.), leaving 30 individuals. Several individuals had more than one hospitalization, and measurements did not separate out the various admissions per individual, but all documentation related to the hospitalizations was used to monitor the quality of the team approach to resolving health care issues to address the cause of the hospitalization or repeat hospitalization. Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDTs did demonstrate one or more processes in a number of cases. The findings included the following: ▪ Reference to a record review/open book review was documented in four of 30 (13%) of individuals. ▪ The IDT identified new triggers or early signs/symptoms in 10 of 30 (33%) individuals. ▪ The IDT identified the need for increased monitoring in one or more aspects of care in eight of 30 (27%) of individuals.	

#	Provision	Assessment of Status	Compliance
		▪ The IDT team identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 13 of 30 (43%) of individuals. There was other evidence of collaborative work and integration of care. For example, the Habilitation Services Department provided training on types of mattresses and surfaces available that would benefit selected individuals. On 6/5/12, a training session was completed. A total of 16 staff attended, including five nurses and a member of the Residential Services Department. Attendance rosters for PNMT meetings were submitted, and tracked the following disciplines' attendance: PNMT RN, dietary, occupational therapy, physical therapy, and speech therapy. For April 2012, attendance at 18 meetings ranged from 89% to 100% for each discipline. For May 2012, attendance at 13 meetings ranged from 92% to 100%. For June 2012, attendance at 22 meetings ranged from 41% (physical therapy) to 100%. For July 2012, attendance at 13 meetings ranged from 69% (PNMT nursing) to 100%. No tracking of PCP attendance occurred. The Medical Department provided information that each PCP attended the PNMT meeting as determined by whether the individual(s) being discussed were on their caseloads. However, from the attendance tracking, it did not reflect if PCPs attended or if there was any communication. It is recommended that the PCPs' attendance be tracked, particularly their attendance or telephone communication during meetings the PNMT specifically requests. It would also be important to ensure the PCPs can efficiently participate or communicate through attendance or phone communication with the team, and that, whenever possible, they be placed first on the agenda or the PCP's schedule is taken into consideration. Weekly, the PNMT provided a report to the provider morning meeting. The minutes reflected discussion from other departments in response to the report, including the PCPs and infection control nurse. It was not clear if there was a database to determine whether PNMT recommendations were completed and the date of completion. Important data would include the percentage of recommendations completed, percentage of recommendations not accepted by the IDT, percentage of recommendations not accepted by the PCPs, and percentage of recommendations accepted, but not completed over a month. Monitoring of referred items from the provider morning meeting were tracked until closure. Monitoring was recorded in a table format, including the individual's name, date of initial discussion and referral, description of the concern, the responsible person, action steps to be taken, closure date, and resolution/closure step. It appeared all concerns from the provider morning meeting were tracked. Closure rates were provided	

#	Provision	Assessment of Status	Compliance
		per month at the end of each month. For April 2012, this was 82%. For May 2012, this was 91%. For June 2012, this was 91%, and for July 2012, this was 80%. According to the Medical Compliance Nurse, unresolved concerns were rolled over to the following month for tracking. It is recommended that the monitoring data reflect closure of ongoing concerns. Tracking not only by month but also on a continuous log would allow determination of whether all cases were closed over time (per quarter, etc.). From the presentation of this initial data, it was not clear if and when the remaining concerns were closed. The data provided evidence that all concerns were tracked to closure, but the data summary did not reflect that important aspect of follow-through. As a follow-up to this concern by the Monitoring Team, the Medical Department provided a list of identified concerns per month, and a determination of when these were closed. For April 2012, there were 10 closure items identified, with 100% closure. For May 2012, there were 10 closure items identified with 100% closure. For June 2012, there were nine closure items identified, with 100% closure. For July 2012, there were 16 closure items identified, with 100% closure. For August 2012, there were 12 closure items identified, with 100% closure. For September 2012, there were 16 closure items identified, with 100% closure. Separately, a document was submitted entitled "IDT Referrals and Individual Support Plan Addendum Tracking." This document focused on tracking ISPAs, and included the following information: name, topic, date of initial request, date of second request, date received, date presented to morning meeting, and the name of the QDDP of the IDT. It is recommended that this form also include a column for whether the provider morning meeting accepted the ISPA content or not. Although LBSSLC had made progress in this area, the Facility remained out of compliance with this provision. The challenge in demonstrating integrated clinical care was several-fold. Maintaining the efficiency and breadth of the provider morning meeting to demonstrate sustainability will be important. From the Monitoring Team's review, the IDTs needed continued guidance and accountability, and an expansion of open record reviews to determine early signs and symptoms helpful in treating illness at an early stage. Documentation of interaction between the PCP and the PNMT at PNMT meetings needed improved tracking. Interaction might include attendance at the meeting or participation through conference call. For the ISPAs that were the written response to a concern assigned to the IDT, there was need to determine if the provider morning meeting participants agreed or not with the ISPA (i.e., did it satisfactorily answer the concern). As discussed in previous reports, 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.	

#	Provision	Assessment of Status	Compliance
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/diagnostic reports for one individual from each residence, as well as any IPNs commenting on the consultant/diagnostic reports. Consultations/diagnostic reports for 15 individuals were submitted, with a range of one to eight consultations/diagnostic reports per individual. A total of 56 consultant/diagnostic reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 56 reviewed, 50 (89%) included the PCP initials, indicating review by the PCP. ▪ Of the 56 reviewed, 50 (89%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. Of the 56 reviewed, three did not require a statement of agreement or not, but were a report interpreting diagnostic tests. Of the 53 for which documentation of agreement or not would be expected, 46 (87%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of the 56 reviewed, 31 (55%) included PCP IPN entries. Additionally, for those for which IPN entries were not submitted, there were 10 (18%) for which PCP orders confirmed agreement and follow-up of recommendations. Combined, there was evidence of agreement through an IPN entry or order entry in 73%. However, although these orders provided evidence of review and processing of recommendations, it is important that consult and diagnostic report results be reviewed in the IPN section of the active record. ▪ Of these, ISPAs for three of 56 (5%) documented the discussion of the contents of the consultant reports, and the PCP's recommendation. A number of ISPAs were submitted, but for some, there was no comment on consultations. At times, there was mention that the individual was to undergo a consultation, and there was discussion of preparation. There appeared to be no feedback loop to ensure the IDT received and reviewed each consult report and significant diagnostic test in a timely manner. The Medical Department completed an internal monitoring of the July 2012 and August 2012 consult recommendations. A 5% sample of consult recommendations was reviewed to determine timely review within five days of receipt of the consult report. It was found that the PCP reviewed all recommendations within one business day (100%). Separately, a database had been developed entitled "Consultant's Recommendations – Tracking." From this database, a sample of 5.83% of 137 consultations completed	Noncompliance

#	Provision	Assessment of Status	Compliance
		between 1/17/12 and 8/21/12 were chosen and reviewed to determine if recommendations were completed. Based on the Facility's data, 87.5% of recommendations were completed. There was one incomplete recommendation that was subsequently corrected. The "IDT Referrals and Individual Support Plan Addendum Tracking" was also applied to refusals and missed appointments for consultation visits. This was to assist in the completion rate of off-site consultations/completion of diagnostic tests, as described with regard to Section L.1. The Facility remained out of compliance with this provision. In addition to ensuring that IPNs include evidence of follow-up to recommendations, the team process for reviewing and documenting review to show integration with existing supports and services required improvement.	

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

1. The PCPs' attendance at PNMT meetings should be tracked, particularly their attendance or telephone communication during meetings the PNMT specifically requests their presence. It would also be important to ensure the PCPs can efficiently participate or communicate through attendance or phone communication with the team, and that, whenever possible, they be placed first on the agenda or the PCP's schedule be taken into consideration. (Section G.1)
2. The provider morning meeting monitoring data should reflect whether all concerns had 100% closure. Tracking not only by month, but also on a continuous log would allow determination of whether all cases were closed over time (per quarter, etc.). (Section G.1)
3. The provider morning meeting team should review the quality of the ISPAs sent back to them to determine if the IDTs addressed the group's concerns adequately. Those that do not should be returned to the IDTs for further consideration. The form "IDT Referrals and Individual Support Plan Addendum Tracking" also should include a column for whether the provider morning meeting accepted the ISPA content or not. (Section G.1)
4. 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)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; o Sample of active problem lists with criteria justifying selected significant diagnoses for: Individual #146, Individual #313, Individual #154, Individual #16, Individual #235, Individual #73, Individual #82, Individual #116, Individual #131, Individual #275, Individual #68, Individual #124, Individual #125, Individual #14, and Individual #310; o For four individuals from each PCP's caseload, four diagnoses with criteria for justification from the active problem list, with supporting documentation, including for: Individual #154, Individual #213, Individual #293, Individual #181, Individual #233, Individual #299, Individual #82, Individual #74, Individual #108, Individual #109, Individual #9, Individual #8, Individual #112, Individual #320, Individual #149, and Individual #215; and o Record review completed by the Medical Department for last six months, highlighting routine departmental assessments, interdisciplinary assessments, identification of acute illness, assessment of acute illness, treatment of acute illness, follow-up to acute illness, and monitoring of chronic illness for Individual #14. ▪ **Interviews with**: o Glen Shipley, DO, MPH, Medical Director; and o Leah Shults, RN, BSN, Medical Compliance Nurse.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: External Medical Peer Review Audit (August 2012), External Medical Management audit, random audits on active problem lists to determine whether a sample of listed diagnoses was verified (20% sample per year), internal quality indicator review (i.e., constipation, diabetes, ER/hospitalizations, seizures, osteoporosis, hypertension). o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with some aspects of Section H of the Settlement Agreement. However, measurement tools should be expanded to include tracking of a comprehensive set of minimum common elements of clinical care throughout all diagnostic categories (i.e., to determine whether or not all appropriate disciplines provided quality care for a diagnosis – from dietary, to PT, to nursing, to medicine, etc.), as well as through time for acute and chronic problems. The one record review submitted was illustrative of a reasonable approach. However, the monitoring aspects needed to be developed, including determining what was to be measured and tracked across record reviews, and the

	parameters and definitions to be used in determining quality of evidence found in the record for a consult report, acute illness, chronic condition, effectiveness of treatment, adequate periodicity of lab testing, etc. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies for some analyses, such as record reviews. However, the Monitoring Team's analysis provided different results for compliance of routine periodic assessments. Further, the record reviews indicated improvement in rates of completion of quarterly medical reviews, indicating databases might be incomplete. o In some cases, the Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Generally, these sample size(s) were adequate to consider them representative samples (e.g., 20% of the individuals over the course of the year). o The Medical Compliance Nurse completed the monitoring/audit tools, and it appeared there was consistency in interpretation of information. This staff was clinically/programmatically competent in the relevant area(s). The QA Department did not appear to have a contribution in monitoring, and therefore, there was no inter-rater reliability. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. Databases included: annual medical assessment tracking, quarterly medical assessment tracking, provider morning meeting closure data, Medical Department database, corrective actions from August external peer review audit, corrective actions from May internal peer review audit, clinical indicators developed by the Medical Director in several clinical areas (e.g., ER/hospitalizations, diabetes mellitus, constipation, seizures, osteoporosis, hypertension). However, the quality of the data maintained in the databases was noted to be potentially incomplete for the medical quarterly reviews. For other audits and data reviews, the information appeared complete and accurate. ▪ One of the strengths was the Facility consistently presented data in a meaningful/useful way with follow through for practical implications in clinical practice. The Facility presented findings consistently based on specific, measurable indicators. ▪ However, the Facility did not consistently measure the quality as well as presence of items (e.g., assessments). ▪ The Facility did not distinguish data collected by the QA Department versus the program/discipline. However, it appeared the QA Department had involvement in monitoring for this section. ▪ The Facility rated itself as being in compliance with subsection Section H.2, and in noncompliance with the remaining sections. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of need/improvement, such as a need for a monitoring system to

	measure health status change, and a monitoring system to provide evidence of timely and clinically appropriate treatment.
	Summary of Monitor's Assessment: The Facility had made some progress with this section. For Sections L, N, and Q, the determination of completion of annual examinations within 365 days or on a quarterly basis, as applicable, was available. As a measure of minimal common elements of clinical care, attendance at the annual ISP also was tracked. The medical management medical peer review also addressed minimum common elements of clinical care. A record audit for one individual was provided as an example of identifying clinical areas essential to care. Such reviews should be translated into clinical measures and tracked over time. The Medical Department had created additional internal quality indicators. However, this was at the beginning stages of implementation, because the database was being developed and implementation of the monitoring had not occurred. Medical diagnoses appeared to have appropriate criteria to justify the diagnosis. As a result, the Facility remained in compliance with Section H.2. A challenge to the Facility was to have the various annual assessments available through a shared drive in preparation for the ISP meeting. This information was used to develop the ratings of the various risk categories in Integrated Risk Rating Form (IRRF). However, there appeared to be a delay in getting completed assessments into this system. The Medical and Dental Departments demonstrated timely completion of annual assessments based on the prior annual date of completion. However, these did not appear to be posted in the shared folder in a timely manner. This negatively impacted teams ability to be fully prepared for ISP meetings There remained a lack of evidence of tracking for some aspects of minimum common elements of clinical care. Taking a specific diagnosis, defining the required disciplines needed to ensure quality care, as well as the required consultations or spectrum of consultations, lab orders, medications, etc., and determining the provision of these treatments and services to a sample of individuals with the diagnosis would provide such evidence. Additionally, tracking evidence of minimum common elements of clinical care for acute care, chronic care, preventive care, and wellness care, would assist in providing necessary evidence.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the	Several routine and period assessments were reviewed for timeliness. These included: ▪ 83 of 97 (86%) medical annual assessments reviewed were completed in a timely manner. ▪ 49 of 82 (60%) dental annual evaluations reviewed were completed in a timely manner. ▪ 226 of 228 (99%) QDRRs were completed in a timely manner. The Facility tracked routine annual assessments for each individual for completion and	Noncompliance

#	Provision	Assessment of Status	Compliance
	timely detection of individuals' needs.	availability approximately 10 business days prior to the ISP. As of September 2012, these were tracked in a submitted computerized document entitled "Individual Support Plan Annual Assessments Spreadsheet." Departments tracked for timely completion of the assessments included: Residential Services, Psychology, Occupational Therapy, Physical Therapy, Speech, Audiology, Nutritional Services, Medical Services, Nursing Services, Dental Services, Recreation Services, Vocational Services, and Day Programming. For each month, a list of the individuals for whom assessments were received and the total assessments due were tabulated. For September 2012, data was submitted. The total number of assessments due varied from seven to 13, as not all individuals required each of the departmental assessments. (Although as discussed with regard to Section F, teams often were still not providing adequate justifications for assessments they deemed as not necessary.) Based on the Facility's data, of the total assessments due, the percentage that were completed in a timely manner varied from 0% for dental services to 100% for audiology, nutritional services, water safety, and day programming. Other departmental compliance with percentage timely completion of assessments included the following: occupational therapy - 33%, physical therapy - 33%, speech therapy - 80%, medical assessment - 31%, and nursing assessment - 38%. Prior to September 2012, an older format of tables was used to track departmental compliance with timely completion of assessments. Information was available for the months of March through August 2012. For the Medical Department, timely completion of the annual assessments per month was as follows: March 2012 – 9%, April 2012 – 20%, May 2012 – 17%, June 2012 - 23%, July 2012 – 11%, and August 2012 – 33%. These percentages were lower than the percentage of annual assessments completed in a timely manner. For instance, as noted above, timely completion of annual medical assessments was 86%, but timely posting into the shared file prior to the ISP was 31% in September 2012. Dental annual assessments approached 60% completion by the due date, but there was 0% compliance in posting it to the shared drive prior to the ISP. It is recommended that the reasons for the documented delay of accessibility of the completed assessments in the shared drive, as well as the challenge of synchronization of the annual due dates and the ISP due dates be reviewed to improve availability of current information prior to the ISP meeting. As is illustrated above, some assessments were regularly being completed in a timely manner, while others were not. As is illustrated in other sections of this report, the quality of assessments also continued to be a concern. The Facility remained out of compliance with this provision.	
H2	Commencing within six months of the Effective Date hereof and with	As evidence for this section, the Medical Department sampled 15 active records to determine whether selected medical diagnoses were consistent with test results and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	examinations filed in the active record, and submitted the results to the Monitoring Team. The method of sampling was not stated. From the active problem lists, one to eight diagnoses were chosen and matched to information in the record verifying the diagnosis clinically. Individuals are listed in the documents reviewed section. Of 57 diagnoses chosen for review, 54 (95%) had evidence provided for the diagnoses through laboratory/radiologic test results, and PCP and consultant assessments. As a method to determine the accuracy of the above findings, the Monitoring Team requested a sample of diagnoses listed in individuals' active problem lists. The sample was derived from four active records from each PCP's caseload. The PCPs were asked to provide the criteria or evidence for four diagnoses from the active problem list to ensure the diagnoses clinically fit the information in the corresponding assessments or evaluations. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). For 58 of 64 diagnoses submitted with supportive documentation (91%), the criteria listed were consistent with the diagnosis listed. For four diagnoses, there was insufficient evidence provided. For two diagnoses, the evidence was not consistent with the provided diagnosis. The findings were similar to the Facility internal review. Although not directly related to compliance with this section, the Medical Compliance Nurse was able to add new International Classification of Diseases (ICD)-9 codes to the medical database as needed. Updates to this medical coding system were automatically provided to the Medical Compliance Nurse. A brief in-service was provided to the PCPs concerning the current status of the ICD-9 and ICD-10 coding systems. This was completed on 9/19/12 and 9/20/12. The psychiatric diagnoses utilized at the LBSSLC were consistent with the nomenclature in the DSM-IV-TR. In addition, as noted with regard to Section J of the Settlement Agreement, review of the psychiatric diagnoses for 19 individuals receiving psychotropic medication found that for all 19 individuals (100%), the records 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. Given that the medical and psychiatric diagnoses generally were consistent with relevant diagnostic criteria, the Facility remained in compliance with this provision.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically	Adherence to the requirements of minimum common elements of clinical care requires interdisciplinary review and discussion of the assessments provided to the IDT to ensure timely and appropriate treatment. One measure of interdisciplinary involvement was the attendance and participation at the IDT meetings. Data was provided for attendance at ISP meetings completed from March through August 2012. Completeness of data was	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate based upon assessments and diagnoses.	determined by the number of ISP signature sheets forwarded to the Medical Department per month in comparison to the number of ISPs completed per month. For March 2012, 16 of 22 signature sheets were received. Clinical departmental attendance (physician, psychologist, nurse) ranged from 64 to 73%. For April 2012, 20 of 21 signature sheets were received. Clinical departmental attendance ranged from 90 to 95%. For May 2012, 16 of 17 signature sheets were received. Clinical departmental attendance ranged from 71 to 94%. For June 2012, 11 of 13 signature sheets were received. Clinical departmental attendance ranged from 62 to 85%. For July 2012, 15 of 19 signature sheets were received. Clinical departmental attendance ranged from 74 to 79%. For August 2012, 20 of 21 signature sheets were received. Clinical departmental attendance ranged from 86 to 90%. PNMT attendance was submitted from April through July 2012, and was discussed with regard to Section G.1. The medical management questions for the external and internal medical provider audits was used as one monitoring tool the Facility used to determine appropriateness and timeliness of clinical care. The diagnoses for the medical management questions included aspiration, constipation, diabetes mellitus, osteoporosis, seizures, and Urinary Tract Infections (UTIs). The results of these reviews are discussed in more detail with regard to Section L.2. The Medical Department provided a record audit for one individual, which is listed in the documents reviewed section. The time period for the review was the six months prior to the Monitoring Team visit. The activities of the clinical departments in providing maintenance care and care in response to changes in health status were highlighted. The following was determined from this review: ▪ There were eight routine departmental assessments. Of these, four had an interdisciplinary component. ▪ There were eight events of acute illness. ▪ For these eight reports of acute illness, there were eight assessments recorded (100%). ▪ For these eight reports of acute illness, there were eight treatments in response to changes in health status. ▪ For these eight reports of acute illness, treatment was timely in eight (100%). ▪ Follow-up assessments were recorded for two acute illnesses. ▪ There were also routine maintenance assessments for two chronic illnesses during this time period. From this sample of one record, there appeared to be several routine assessments completed in the six-month time period. As routine assessments are often completed on	

#	Provision	Assessment of Status	Compliance
		an annual basis or less frequently depending on the clinical department, it could not be determined if the routine assessments were current for all clinical disciplines. The response to acute illness was well documented and timely. Although it was positive that the Facility had begun to review records to determine if timely and clinically appropriate treatments are provided, the Facility was in the beginning stages of this process. It is recommended that the Medical Department develop a monitoring tool that reflects the record audits, and breaks the components into routine assessments, acute illness reports with assessments, treatments, and timeliness indicators, and chronic illness conditions with assessments, treatments, and timeliness indicators (as appropriate). In addition, as noted in the previous report, the Facility should use the current clinical guidelines to create a set of clinical indicators to measure the timeliness and adequacy of clinical care. As discussed with regard to Section H.4, the Facility had begun work on this, which was positive. The State Office also 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.	
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.	The Medical Department at LBSSLC has created internal quality indicators for several diagnoses common to the IDD population. Quality indicators were developed for osteoporosis, seizures, ER/hospital visits, hypertension, constipation, and diabetes mellitus. Three to five quality indicators were chosen per diagnosis. Four (i.e., osteoporosis, ER/hospital visits, hypertension, and diabetes mellitus) of these referenced recommendations from the Agency for Healthcare Research and Quality (AHRQ). One (i.e., diabetes mellitus) also referenced recommendations from the Consortium for Performance Improvement (American Medical Association). These indicators were considered a separate quality assurance tool from the medical management audit. For each of these diagnoses, a 5% sample annually of the population at LBSSLC was audited. However, this was at the beginning stages of implementation, because the database was being developed and implementation of the monitoring to collect data related to the indicators had not occurred. The Facility has developed clinical indicators of efficacy of treatment for these six areas. This was a very positive development. However, the requirements of Section H.4 require broader development of clinical indicators to measure the efficacy of treatment. The Facility is encouraged to expand this list to include other clinical areas of care common to the IDD population, as well as expand to other disciplines and interdepartmental concerns, such as psychiatric concerns, obesity, gastroesophageal reflux disease (GERD), and oral hygiene.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	Both the external and internal medical peer included questions that assisted in measuring the quality of health care provision. The medical management questions focused on six diagnoses common to the IDD population, and the general medical audit provided periodic monitoring (every three months) for a selected sample of individuals residing at LBSSLC. However, monitoring of health status of all the individuals at LBSSLC will require additional monitoring efforts. The provider morning meeting would be one approach to monitoring health status across campus, because many changes in health status are identified, and discussions are documented for individuals with significant changes or new findings. For the Medical, Dental, and Pharmacy Departments, tracking of timeliness of annual and other periodic assessments utilized databases available to the applicable departments. For example, data such as the following was available: ▪ 116 of a total expected 321 (36%) medical quarterly reviews were completed in the prior six months; and ▪ 226 of 228 (99%) QDRRs were current. However, monitoring the content of these assessments (not just timeliness of completion) to determine health status, and identify those with changes in conditions, would be an additional approach. 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. 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. One of the areas needing further focus was tracking minimum common elements of clinical care required on an ongoing basis for preventive care and wellness, as well as routine care of diagnoses common to the IDD population. The Facility remained out of compliance with this provision.	Noncompliance
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 provider morning meeting minutes allowed tracking of acute illnesses to determine whether immediate and acute interventions were completed in a timely manner. Additionally, the provider morning meeting requested that a number of IDTs respond through ISPA development to address ongoing needs of the individuals. Accountability should have occurred when the ISPA was returned back to the Medical Department, and was reviewed and approved by the participants of the provider morning meeting. However, at the time of the Monitoring Team's review, documentation only showed when the ISPA was returned. No information was included to show the provider morning meeting team had determined the quality or content of the ISPA in addressing	Noncompliance

#	Provision	Assessment of Status	Compliance
		health status change, and whether treatments and interventions were to be changed based on the IDT decisions, or were to remain the same, with or without change in monitoring. In addition, the provider morning meeting generally only addressed acute changes in status. No information was submitted that tracked changes in treatments and interventions based on signs and symptoms used as clinical indicators.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility adapted and incorporated the following State Office clinical guidelines into its own policies and procedures: ▪ LBSSLC - Health Services: Clinical Guidelines – Diabetes, dated 1/13/12, in-service dates: 2/9/12, and 3/16/12; ▪ LBSSLC – Health Services: Clinical Guidelines – Enteral Feedings, dated 1/13/12, in-service dates: 2/9/12, and 3/16/12; ▪ LBSSLC – Health Services: Clinical Guidelines – UTI, dated 2/3/12, in-service dates: 2/9/12, and 3/16/12; ▪ LBSSLC – Health Services: Clinical Guidelines - Constipation, dated 1/13/12, in-service dates: 2/9/12, and 3/16/12; ▪ LBSSLC – Health Services: Clinical Guidelines – Aspiration Pneumonia, dated 1/13/12, in –service date: 3/16/12; ▪ LBSSLC – Health Services: Clinical Guidelines – Osteoporosis, dated 1/13/12, in-service dates: 2/9/12, and 3/16/12; and ▪ LBSSLC – Health Services: Clinical Guidelines – Seizures, dated 1/13/12, in-service dates: 2/9/12, and 3/16/12. As part of the "at risk" process, as well as addressing Sections H.1, H.3, H.4, H.5, H.6, and H.7, LBSSLC implemented a policy entitled: LBSSLC- IDT Process – Program Development: Individual Support Plan – At Risk Process, dated 9/10/12. It incorporated many of the Settlement Agreement expectations for Section H, including routine assessments as well as assessments for change of status. An appropriately implemented risk process would also provide evidence for each of these subsections in H. A number of important processes were in place and were well documented (e.g., the provider morning meeting, the referral process through the QDDP Educator to the IDT, the review of the ISPA through the provider morning meeting, attendance tracking for department representation at the morning meeting). It is recommended that the Facility create a policy/procedure that provides the blueprint of these system processes and interfaces, and captures the current activity at the Facility. It also should demonstrate where the "at risk" process is integrated into this process and at what level(s). If not already clarified in a policy, guidance should be written regarding the specific areas the	Noncompliance

#	Provision	Assessment of Status	Compliance
		IDT is expected to review in follow up for individuals hospitalized or going to the ER, including providing evidence of the discussion and IDT decision through documentation in the ISPA. Additionally, there should be a policy focusing on monitoring of these interlocking systems, measuring each to ensure the process is functional and efficient to meet the needs of the individual. It is recommended this oversight monitoring process include quarterly QA reports, as well as an outline/guidance in the policy of the administrative steps to take corrective action based on these quarterly analyses.	

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

1. The reasons for the delay of availability of completed medical assessments in the shared drive and the challenge of synchronization of the annual assessment due dates and the ISP due dates should be reviewed and improvements made to ensure the availability of current medical information prior to the annual ISP meetings. (Section H.1)
2. 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)
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 treatment of that diagnosis have been included in an integrated action plan. (Sections H.1 and H.3)
4. It is recommended that the Medical Department 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/integrated health care plans 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 evidence of assurance that individuals have adequate access to the minimum common elements of clinical care. (Section H.1)
7. The Medical Department should develop a monitoring tool that reflects the record audits being conducted, and breaks the components into routine assessments, acute illness reports with assessments, treatments, and timeliness indicators, as well as chronic illness conditions with assessments, treatments, and timeliness indicators (as appropriate). (Section H.3)
8. The State Office should continue to create clinical guidelines for other diagnoses common to the IDD population. (Section H.3)
9. The Facility should continue to develop a set of clinical indicators/outcome measures to assist in determining if treatments and interventions are implemented and effective. (Sections H.3 and H.4)
10. 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: ▪ **Review of Following Documents**: o DADS SSLC revised "Risk Guidelines" laminated record, dated 6/18/12; o Annual Integrated Risk Rating Form (IRRF), dated 5/31/12; o Change of Status Integrated Risk Rating Form, dated 5/31/12; o Risk/Integrated Health Care Plan (IHCP) Developmental and Contact Team curriculum and training rosters; o ISP Prep – Meeting Overview curriculum and training rosters; o Section I Monitoring Tools and At Risk Guidelines; o Individual Support Plan Monitoring Checklist Meeting Review, Individual Support Plan Monitoring Checklist Documentation Review, and Individual Support Plan Change of Status Documentation Monitoring Checklist; o Quality Assurance/Quality Improvement Council minutes, dated 1/31/12; o Quality Assurance/Quality Improvement Quarterly Summary – July 26, 2012 (covers April, May, and June 2012); o Section I raw audit data for March through August 2012; o LBSSLC Presentation Book for Section I; o LBSSLC's Self-Assessment and Action Plans; o LBSSLC's Provision Action Information; o LBSSLC At-Risk Individuals list; o Draft of Individual Support Plan – At Risk Process, dated 9/10/12; o The following documents: Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following: Individual #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #276, Individual #160, Individual #74, Individual #235, Individual #94, Individual #220, Individual #52, Individual #204, Individual #232, Individual #136, Individual #164, Individual #312, Individual #183, Individual #178, and Individual #1; and o For the following individuals' active records, selected documents, including: DG-1; most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past year of IPNs; past year of lab results, x-rays, scans, MRIs, ultrasound reports, and hospital discharge summaries; ER report past one year; consults and procedure reports past one year; DNR forms, if applicable; physician orders for past one year; most recent ISP and subsequent addendums; most recent BS; past three medical quarterly reviews; integrated risk rating forms for past one year; and risk action plan for past one year, for the following individuals: Individual #252, Individual #181, Individual #147, Individual #322, Individual #45, Individual #308, Individual #9, Individual #8, Individual #19, Individual #242, Individual #3, and Individual #2. ▪ **Interviews with**: o Robin Seale, Assistant Director of Programs; o Jeremy Ellis, RN, Chief Nurse Executive (CNE);

	○ Eddie McFadden, RN, QA Nurse; ○ Linda Thomas, Occupational Therapist – Registered (OTR), Habilitation Therapies Director; and ○ Samantha Garza, Administrative Assistant. ▪ **Observations of**: ○ ISP meetings for Individual #258, on 10/1/12, and Individual #140, on 10/4/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I, dated 9/17/12. In its Self-Assessment, for each subsection, 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. Overall, the content and organization of the Facility's Presentation Book addressing Section I was exceptional. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. At the time of the review, the Facility was in the process of modifying its monitoring tool for Section I, recognizing that the current monitoring tool did not include all the provisions of the Settlement Agreement for the different subsections of Section I, and had collected some initial data throughout the review period. From discussions with the Assistant Director of Programs, she had conducted the auditing for the monitoring data that was presented in the Facility's Self-Assessment and candidly reported that since she was not a clinician, the data generated did not reflect the quality of the documentation reviewed regarding the at-risk system. However, based on a review of the Facility's Self-Assessment: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included the Section I: At Risk Individuals, Individual Support Plan Monitoring Checklist Meeting Review, Individual Support Plan Monitoring Checklist Documentation Review, and Individual Support Plan Change of Status Documentation Monitoring Checklist, for the months of March through August 2012. Although the Self-Assessment referenced that for each month, a random sample was audited of four individuals (n) out of the total population (N), it was unclear why the Self-Assessment data was reflective of a sample chosen from the total number of ISPs for a particular month. To clarify this, the monitoring process described in the Section I Presentation Book would need to include a clearer description regarding the characteristics of the total population and how the sample of four was selected. Although the Section I: At Risk Individuals monitoring tool had associated guidelines for scoring the tool, the lack of instructions/guidelines; lack of identification of the specific criteria the Facility used in assessing compliance for the items found on the Individual Support Plan Monitoring Checklist Meeting Review, Individual Support Plan Monitoring Checklist Documentation Review, and Individual Support Plan Change of Status Documentation Monitoring Checklist monitoring tools; and the lack of auditing regarding the quality of the documentation rendered much of the data included in the Self-Assessment uninterpretable. ○ As the Facility recognized, the current monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. As the Facility revises its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. The addition of the Individual Support Plan Monitoring Checklist Meeting Review, Individual Support Plan Monitoring Checklist Documentation Review, and Individual Support Plan Change of Status Documentation Monitoring Checklist was a very promising step forward in aligning the items to be monitored with the elements of

	the Settlement Agreement provisions and the Monitoring Team's indicators. o As noted above, the current monitoring tools were the Facility's initial attempt at improving the monitoring tools to ensure they were aligned with the elements of the provisions for Section I, and the revised tools were still under revision at the time of the review. However, based on review of the monitoring tools contained in the Presentation Book for Section I, they did not include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. As a result, it was likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews. In addition, further definition was needed with regard to the criteria auditors would use to rate the various indicators. Thus, there was a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools were an accurate reflection of the area being audited. o As noted previously, the Self-Assessment identified the sample sizes for March and April 2012. However, without a description of how the total population from which the samples were pulled was determined (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.), it was not possible to determine the relevance of the data. Although the Monitoring Team recognized that the Self-Assessment data for Section I was an initial attempt to generate data for this area, a review of these data indicated that there was considerable variability in the samples sizes for the different items that were being audited without explanation. After clearly identifying the total population (N) used to define the sample selected, (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored. o As noted above, although the ADOP conducted the monitoring for the data contained in the Self-Assessment for Section I, at the time of the review, the QA Nurse had become responsible for completing the audit tools. However, the Facility had requested and was granted approval by the QA/QI Council in January 2012, to suspend monitoring for Section I due to the state-wide system revisions that were being implemented by all the SSLCs. From discussions with the ADOP, she recognized that that the data generated from her audits did not reflect the clinical quality of the documentation reviewed, and she had not been deemed competent in the use of the tools or deemed programmatically/clinically competent in the relevant area(s). As noted during several past reviews and in the Monitoring Team's previous reports, the quality and adequacy of the assessments conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. Unfortunately, the Facility's current process of monitoring and the data generated for Section I did not capture this essential issue. The Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. In order to adequately assess compliance based on critical clinical thinking, the auditor(s) for this crucial area should have the appropriate clinical background. o At the time of the review, adequate inter-rater reliability had not been established for the Section I monitoring tool. ▪ Due to the lack of an adequate written procedure addressing the process of developing and implementing monitoring tools, lack of established inter-rater reliability, and overall data presentation, the Facility did not yet consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators. For example, as noted

	above, at times, it was unclear what specific criteria had been used to determine compliance. In addition, at times, items contained on the monitoring tool included more than one item, such as "objectives within the action plans were measurable and designated a person responsible for data review," making it impossible to determine which of these requirements were found to be in compliance and which had not. o Did not measure the quality of the documentation versus merely the completion of the documentation. ▪ The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, of concern, none of the indicators included in the Self-Assessment reflected the quality aspect of the indicators. Although some of the initial data generated from the Facility regarding issues such as required timeframes were in alignment with the Monitoring Team's findings, other areas addressing clinical areas were noted to have resulted in higher compliance scores than the Monitoring Team found. In reviewing the Monitoring Team's report, the Facility should attempt to determine how quality will be assessed, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data. ▪ Overall, the Facility's data identified a number of initial areas in need of improvement. From discussions with the ADOP, CNE, and Habilitation Therapies Director, a number of internal tracking systems recently had been initiated that also indicated significant gaps in the system. Although the Facility was clearly able to articulate a number of the barriers affecting many of the areas in need of improvement, the Facility Self-Assessment did not provide an analysis of this crucial 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.
	Summary of Monitor's Assessment: Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that would be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition (APEN) was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. In July 2012, two teams at LBSSLC had been trained on the new policy and processes, and during the week of the Monitoring Team's onsite review, had begun to pilot them. One team supported individuals with medically complex issues and the other team supported individuals with psychologically complex issues. It was important that the new system was being piloted with two teams to determine any additional implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRFs indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing

	consistency across campus and improving the quality of the process. Until now, the quality of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at LBSSLC. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and overall, more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of revisions to the IRRFs, dates of revisions, measurable and/or observable objectives, and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Interviews with the Facility staff, review of LBSSLC's Self-Assessment, and Provision Action Information documents indicated that since the last review, the following steps had been implemented regarding the At Risk process: ▪ Since the Monitoring Team's last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines that included seven groupings of risk categories. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers (trigger sheet indicated/not indicated), and criteria for IDT review. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that would be completed annually; different forms for the IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms to alert the staff to possible changes in status. Trigger data sheets were to be completed and implemented according to the high-risk category. When there was a change of status (according to the definition provided in the instructions), a change of status integrated risk rating form was to be completed. Each of the risk categories for that individual was to include a log of the monthly review by discipline. There was a separate form, entitled "Direct Support Professionals	Noncompliance

#	Provision	Assessment of Status	Compliance
		Instructions" to be completed for an identified high-risk category. It was to be completed by the home manager/charge and signed off by each direct support professional caring for the individual. ▪ Although many of the activities listed in the Provision Action Information regarding Section I during the beginning of the review period were suspended in response to the state-wide revisions to the At-Risk system, since that time the Facility implemented a number of systems in an effort to begin to track some of the basic elements of the risk system. For example, a random audit of the active records was conducted in May 2012, to ensure that the risk rationale documents were present. Although the Facility's Self-Assessment indicated that some issues were found, there was no indication what actions were actually taken and what was the result of those actions in addressing the problematic issue. In addition, in June 2012, the Facility developed and implemented a database to track the completed draft Integrated Risk Rating forms. Although a positive step forward, there was no information provided in the Self-Assessment or other documentation submitted regarding the outcome of this action. ▪ In July 2012, a positive step forward the Facility made was initiating discussions in the morning provider meetings about team meetings and ISPAs that were needed to address issues related to individuals' changes in status. In addition, a tracking form had been implemented that included information, such as the name of the individual requiring an ISPA, any requests for information or referrals made at the meeting, the date the request was made, the date that the QDDP received the request, and the date when the issue was closed. However, as is discussed with regard to Sections G and L, it was not clear that the morning provider meeting team was reviewing the quality of the ISPAs that teams returned, and ensuring that the teams had taken adequate steps to address the concerns identified. ▪ The Facility reported that in July 2012, training was conducted regarding the Enhanced Risk and new Integrated Health Care Plan process. A review of the curriculum found it to be comprehensive and a promising step forward for the Facility's at-risk individuals. In addition, training was also provided regarding the revised format and purpose of the Aspiration Pneumonia/Enteral Nutrition as a data collection document to assist with Risk Discussions. ▪ In July 2012, two teams from LBSSLC implemented the "Enhanced Risk Process" described above at Residences 504 W and 514. One team supported individuals with medically complex issues and the other team supported individuals with psychologically complex issues. Since the first annual ISP meetings using the new process occurred the week of the Monitoring Team's onsite review, the Monitoring Team was not able to adequately assess any progress made from the system revisions. ▪ Changes in the at-risk process were identified that affected the Medical	

#	Provision	Assessment of Status	Compliance
		Department, Psychiatry Department, and Dental Department included the following: o A submitted document entitled "Annual ISP Meeting IDT Attendance Indicators," dated 6/11/12, provided guidance concerning PCP attendance at the ISP. Attendance was required for discussion of an individual's medical areas rated high or medium risk. Also, when an individual had chronic medical conditions that had an impact on program activity participation, the PCP was required to participate in those discussions. It was noted that if a PCP was unable to attend the entire annual ISP meeting, the minimum requirement was attendance during discussion of the integrated risks and resulting action plans in response to those risks. o For psychiatry, this document noted that attendance was required at the ISP when the individual received psychoactive medication. If there were other time commitments, the psychiatrist was expected to attend the portion of the ISP in which there was integrated risk rating/discussion concerning use/justification of psychoactive medications and resulting action plans. o For the Dental Department, attendance was required when an individual was considered high risk for dental concerns or areas in which dental care/oral hygiene had a potential impact, such as aspiration and respiratory compromise. Attendance was also required when the individual received dental desensitization. If the dentist was not able to attend the entire ISP, then the minimum requirement was attendance during discussion of the integrated risks and resulting action plans in response to those risks. ▪ Although in a positive step forward, the Facility had initiated a Risk Work Group during the previous review to focus on system issues regarding the at-risk individuals, it was troubling to see that meetings scheduled for 5/22/12, 5/29/12, and 6/5/12 were cancelled "due to lack of attendance." ▪ At the time of the review, the Facility reported that there had been no system developed to track changes in status since the current processes in place did not lend to capturing this information. Although the Facility did have a system to track emergency room visits and hospital admissions, the Monitoring Team reinforced the notion that from findings from past reviews, acute changes in status were occurring prior to emergency room and hospital admissions that also needed to be addressed through the At-Risk system. The Facility's Self-Assessment indicated that based on the findings of the self-assessment this provision was not in compliance as evidenced by a lack of effective, integrated action plans that managed identified risks for individuals. Also, the current documentation	

#	Provision	Assessment of Status	Compliance
		regarding the risk system did not allow the determination of when a plan was actually implemented. The Monitoring Team's findings supported some of the Facility's initial monitoring data and findings, albeit based on very small sample sizes and other basic missing elements, that it was not in substantial compliance with the Settlement Agreement requirements for Section I. However, the Monitoring Team's finding was also based on a comprehensive review of the clinical quality and adequacy of the current documentation for individuals that were identified as being at risk by their teams, which was not reflected in the Facility's monitoring data. Although the Facility very recently had implemented a promising new pilot At-Risk system, as noted below, the Monitoring Team found a significant number of problematic issues in the existing At-Risk system at the time of the review. Overall, the recent changes made in the At-Risk system appeared to be positive. A review of some of the ISPs and addendum documentation indicated that individuals' teams were having more comprehensive discussions of the individuals' status, and including more pertinent clinical information in the Integrated Risk Rating Forms than found during previous reviews. However, the overall lack of clear documentation included in the ISPs, Integrated Risk Rating Forms and revisions, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of structure, dates, and specific supporting documentation addressing actions and completion of action plans made it difficult to determine a clear sequence of events in response to risk issues. Although the pilot regarding the promising new changes in the At-Risk system had only begun during the week of the review, the lack of progress in the existing At-Risk system used since the last review was very troubling at this juncture of the compliance process. While the Monitoring Team agreed that changes to the At-Risk system needed to occur in order for the Facility to achieve substantial compliance, the numerous changes to the At-Risk system had resulted in fragmented documentation that made it difficult, if not impossible to sequentially follow the assessment and action plan processes for the samples of individuals who the Facility determined to be at high risk regarding health and/or mental health issues. To assess the Facility's revised risk screening process, members of the Monitoring Team observed two individuals' ISP meetings (i.e., Individual #258 and Individual #140) while on site. These ISPs were the first ones conducted by the Facility that were reflective of the new ISP format and process, and thus were chosen for that reason. Specifically, the observations of the ISPs indicated that: ▪ In none of the two (0%) all appropriate disciplines were present at the observed ISPs. Dental representation was not present at either ISP in spite of high and	

#	Provision	Assessment of Status	Compliance
		medium dental risk ratings for Individual #258 or Individual #140, respectively. In addition, there was no direct support professional present at the ISP for Individual #258. ▪ The staff present at the ISP meetings appeared to be the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for both meetings (100%). ▪ Both individuals (100%) were present for their ISP meetings, and left the meetings at times based on their choice. ▪ Neither of the IDTs (0%) consistently used the Risk Level Guidelines when determining risk levels at the ISP meetings. ▪ Neither IDT (0%) consistently used supporting clinical data when determining risks levels for the ISPs observed. Although improvements were seen with regard to the use of clinical data, the Monitoring Team noted that there was limited information contained on the IRRF for some of the health indicators, such as dental hygiene ratings, specific medications that indicated a risk of polypharmacy, specific monthly values for risk associated with weights, the dates and types of fractures and injuries, and specific medications and number of as needed or pro re nata (PRNs) addressing constipation risks. ▪ Due to the limited clinical information contained in the IRRFs for some of the health categories, the Monitoring Team was not able to determine if all designated risk levels were appropriate. ▪ Due to the limited information contained in the IRRFs for some of the health categories, there needed to be more clinical discussions amongst the team members in order to appropriately and accurately make decisions regarding risk levels for the ISP meetings observed. ▪ Team disagreements regarding risk levels were noted at the ISP meeting for Individual #140 regarding the presence or absence of gastroesophageal reflux disease (GERD), and thus, the presence or absence of an existing risk. Since the team was not aware that the PCP had discontinued this diagnosis and the team had services in place addressing this issue such as positioning and dietary strategies, the team did not adequately process a 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. ▪ Based on both ISPs observed, the ISP facilitators made good attempts to keep the teams focused while trying to navigate a new process. Areas for continued focus included time management since the ISPs observed were lengthy, presenting justification for risks levels in alignment with the Risk Guidelines and individual-specific clinical information, continuing to increase team discussions of risk indicators, and developing adequate Integrated Health Care Plans. In addition, as discussed with regard to Section F, additional processes needed to be in place to keep the teams focused.	

#	Provision	Assessment of Status	Compliance
		In addition, other positive observations of the ISPs for Individual #258 and Individual #140 included: ▪ PNMT members (i.e., RN, Physical Therapy Assistant, and Physical Therapist) attended the ISP for Individual #258. In addition, the PCP was present throughout the meeting, and provided relevant clinical information to the team, especially when the team was discussing and finalizing triggers for each risk rating. Also, the team discussed the current supports that were in place for each risk rating. ▪ In discussing risk areas, the team made recommendations for changes to Individual #258's PNMP. These changes were confirmed during the meeting, and the team approved the "revised" PNMP. ▪ Some of the objectives the team discussed for Individual #258 were measurable and individualized. For example, an objective was developed for his oxygen saturation rates to remain at 92% or above. ▪ The team for Individual #258 had included in action plans a number of specific steps that direct support professionals would take. For example, their roles were defined with regard to the completion of trigger sheets and other data collection tools, and the training that clinical staff needed to provide direct support professionals also was identified. In addition, some specific preventative supports were detailed, such as the specific amount of fluid that direct support professionals would offer him each shift, and the team specified the documentation method on the food and fluid sheet. In addition, weekly monitoring of fluid refusals was assigned to the nurse. ▪ Although an area that continued to require improvement, the team for Individual #258 discussed some of the monitoring that would need to occur to ensure adequate supports were being provided. For example, an objective was developed to monitor compliance with his PNMP, including his dining plan and transfers, at least twice each quarter. The team identified the tool that would be used for monitoring. However, this action would have been enhanced had the team better defined the specific shifts on which this monitoring would occur. ▪ Overall, the IDTs provided more clinical justification for the risk ratings than previously on the IRRFs and through many of the teams' discussions. ▪ The ISP meeting for Individual #140 showed good integration between psychology, speech and language therapy, as well as vocational. Working together, they had identified some supports to assist the individual with his communication, including both receptive and expressive skills. In turn, this had had a positive impact on his behavior. ▪ Individual #140's preferences had clearly been integrated with his communication and behavioral supports. In addition, the individual's mother was an active participant in the process.	

#	Provision	Assessment of Status	Compliance
		▪ For some of the risk indicators, the team identified and discussed measurable objectives that would assist in maintaining the individual's health, such as requiring nursing to notify the PCP of a 10-pound weight increase or loss for Individual #140. ▪ Based on observation of the ISP meeting for Individual #140, although continued work on this was still needed, some of the IHCPs developed by the team included good specific definition of which team members were responsible for what. For example, the action plan for constipation included the preventative measure of drinking three liters of fluid. Direct support professionals were identified as responsible for documenting his intake of three liters of fluid, and nursing staff were identified as responsible for monitoring the documentation. A list of signs and symptoms of constipation also were identified for direct support professionals to monitor, and report to nursing. Nursing was then responsible for assessment of Individual #140 should such signs be identified. Areas in which more work was needed to obtain full team participation and facilitate meaningful discussion included, but was not limited to: ▪ The Monitoring Team recognized that the ISPs observed were the initial ISPs using the new process, and thus were extremely lengthy. As the process continues, strategies to facilitate the process should be considered such as having draft IHCPs made available to the team before the meetings, and during the meetings, providing more of a summary of data included on the IRRFs to make the meetings more time efficient and manageable. ▪ Although there was mention of nursing protocols during the ISPs, they were not used when developing the IHCPs for risk indicators. Consequently, most of the nursing interventions discussed at the ISPs were not adequate in addressing the health risk indicators and did not address the needed clinical assessments to ensure the health indicators were actually being monitored. ▪ It was positive that the Integrated Health Care Plans for Individual #258 were reviewed in some detail with the team. However, the meeting time would have been used more efficiently if: a) they were discussed directly following the grouping of risk areas to which they applied; and b) team members had been provided a draft ahead of time, and had come prepared to discuss necessary changes. Of course, based on discussion during the meeting, more changes might be needed. ▪ Although Individual #258 was noted to be at high risk for aspiration and had a diagnosis of dysphagia, there was no discussion by the team regarding the results of a Head of Bed Elevation assessment. ▪ Staff reported Individual #258 aspirated emesis during a seizure. In addition it was reported he had several incidences of vomiting this year in the draft IRRF. However, there was no discussion of PNMP strategies regarding how staff was to	

#	Provision	Assessment of Status	Compliance
		position the individual in the event he experienced additional episodes of emesis to minimize his risk for aspiration. ▪ There was no discussion of whether Individual #258 had a diagnosis of GERD during the team's discussion addressing GI Risks. ▪ The IRRF noted that Individual #258's blood pressure and heart rate was "within normal limits" without the specific values noted to determine the health status for cardiac risk. ▪ In developing action plans, the team for Individual #258 did not consistently identify measurable objectives, and/or objectives that assisted the team to determine if he was doing better or worse, or remaining the same. For example, the team agreed to objectives or outcomes that used terms such as "reduced incidents of…" for measuring success with the PNMP without defining any baseline by which to measure a reduction. Similarly, when discussing an objective for the action plan related to polypharmacy, the team struggled unsuccessfully to draft a measurable objective. ▪ Although the team identified some of Individual #258's preferences and strengths at the beginning of the meeting, they were not incorporated in any meaningful way in the action plans the team discussed. ▪ Dental staff were not present at the ISP meeting for Individual #258, so this limited the discussion of dental supports. However, the team identified him as being at high risk, and, in writing, the dentist had recommended that Individual #258 undergo dental procedures under general anesthesia. The reason stated was that Individual #258 had missed three dental appointments. However, it appeared that this was due to his being hospitalized at the time of two appointments, and not having maintained "nothing by mouth" status for one. Although the team did not discuss the previous appointments, it was unclear why other appointments with the dental clinic were not scheduled. In addition, the waiting list for general anesthesia was a year. The team should have identified this as a "barrier" to meeting one of his needs, but they did not. Although the team recognized the need to inquire further with the dentist, at the time of his ISP, an adequate dental treatment plan was not in place. ▪ The team struggled with the development of measurable objectives for Individual #140's Integrated Health Care Plans. For example, no measurable objective was stated for his dental action plan. Similarly, in discussing action plans, the team used terms such as "encourage physical exercise," which was not measurable. ▪ The role of Individual #140 in his health care was not consistently considered. For example, Individual #140's team discussed extensively a change in medication for constipation, and the need to know the impact of this change. However, given that he self-toileted, Individual #140's team did not discuss whether he could self-report when he had a bowel movement, or if there might	

#	Provision	Assessment of Status	Compliance
		be a way for him to fill in a calendar or log. ▪ Although the team for Individual #140 had some discussion about potentially reducing the polypharmacy for psychotropic medication, little to no discussion occurred regarding the risks versus the benefits of the medication, the justification for the polypharmacy, and/or the alternatives to medication. Also, no data was presented regarding the specific psychiatric symptoms that were being monitored. Although it was positive that the team agreed that the psychologist and psychiatrist would collaborate on a measurable objective related to the psychiatric symptoms, it was concerning that such an objective was not already in place. ▪ Although Individual #258's IRRF addressing fluid imbalance indicated that supports were in place to prevent this, the specific supports were not defined. In addition, the IRRF stated supports were already in place for urinary tract infections (UTIs) and were effective. However, the individual had experienced two UTI's in the past year without a comparison to the previous year supporting the notion that the current supports were in fact effective. ▪ A significant lack of communication was evident between the medical provider and the team regarding the discontinuation of a diagnosis of GERD during the ISP for Individual #140. Although the team took the time during the meeting to address each of the services related to GERD that had been put in place to determine if they were still warranted, such as positioning and dietary strategies, it was clear that most, if not all of the team members were not involved and/or informed of the change in diagnosis. From the Monitoring Team's limited observations of two ISPs and review of documentation, there had been some positive steps made regarding the structure and format of the ISP meetings and documents, specifically the increased use and team discussions of supporting clinical data when assessing risk levels. However, considerably more efforts are needed to ensure that the appropriate risks levels are assigned based on the clinical data, that the IHCPs reflect the needed clinical intensity in alignment with the appropriate designated risk levels, that objectives are functional and/or measurable, that adequate preventative measures are discussed and are included in the IHCPs, and the entire process is clearly documented. In addition, the Facility should implement a system to address the reassessment of risk factors for individuals experiencing significant changes in status, including acute changes in status for at-risk individuals. Such a system should not only be activated in response to hospital admissions. LBSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with	Based on a review of records for 22 individuals determined to be at risk (i.e., Individual #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	#298, Individual #324, Individual #276, Individual #160, Individual #74, Individual #235, Individual #94, Individual #220, Individual #52, Individual #204, Individual #232, Individual #136, Individual #164, Individual #312, Individual #183, Individual #178, and Individual #1), 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 none of these (0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms (IRRFs) did not consistently include specific clinical data to support the risk ratings for the health indicators, such as including the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls and fracture risks. Thus, the Monitoring Team was unable to determine if further assessment was needed; ▪ Due to the lack of documented dates on the various forms, the Monitoring Team was unable to consistently determine what new information was added to a revised Integrated Risk Rating form, and what additional assessments were needed and/or conducted in response to the revised information or possible change of status; and ▪ When recommendations for further assessment were found on the Risk Action Plans, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not consistently correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was not possible to determine what precipitated the recommended assessment, and if it was timely completed. <u>Nursing Assessments</u> 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 #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #276, Individual #160, Individual #74, Individual #235, Individual #94, Individual #220, Individual #52, Individual #204, Individual #232, Individual #136, Individual #164, Individual #312, Individual #183, Individual #178, and Individual #1. In addition, consistent with previous findings from the Monitoring Team, a review of the most current quarterly 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 of the Comprehensive Nursing Assessment form. Unfortunately, the Comprehensive Nursing Assessments the Monitoring Team	

#	Provision	Assessment of Status	Compliance
		reviewed were noted to have regressed from the previous review in that some of the nursing assessments did not reflect any clinical information regarding the health risk indicator while others merely listed the entries from the IPNs or physician orders. As noted from the previous five reviews, nursing continued to have no specific procedure in place regarding the nursing assessment process and the analysis of the identified risk indicators. As noted from past reviews, the nursing assessments for the At Risk individuals were not adequate in addressing the health risks of the individuals reviewed. Regarding the Integrated Risk Rating forms, although overall more specific clinical information was contained on the forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, a decrease in this individual-specific information was noted from the previous review. In addition, when reviewing some the Integrated Risk Rating forms that included dates of revisions, the areas that contained deficits in individual-specific information remained unchanged. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Medical Assessments</u> Record reviews were conducted for 12 individuals, including Individual #252, Individual #181, Individual #147, Individual #322, Individual #45, Individual #308, Individual #9, Individual #8, Individual #19, Individual #242, Individual #3, and Individual #2. Of these, seven had hospital or ER visits following the annual ISP, including Individual #308, Individual #242, Individual #147, Individual #8, Individual #45, Individual #1, and Individual #9. Copies were requested of ISPs and any follow-up ISPAs after the annual meeting. The records were reviewed to determine the timeliness and quality of the IDT response/ISPA development in response to a change in health status. A review of the medical assessment focused on documentation of tests and consultations to address the change of health status in order to guide the team in creating appropriate risk ratings and action plans. Based on a review of seven individuals' records in response to changes in an at-risk individual's condition, there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for two of seven (29%) individuals. Records that did not contain documentation of this requirement included Individual #308, Individual #242, Individual #147, Individual #8, and Individual #45. Based on a review of seven individual records for whom assessments had been completed to address the individuals' at risk conditions, four of seven (57%) included an adequate medical assessment to assist the team in developing an appropriate plan.	

#	Provision	Assessment of Status	Compliance
		Records that did not contain documentation of this requirement included Individual #308, Individual #242, and Individual #45. The following provide examples of the lack of evidence of response by the IDT to a change in health status, and/or concerns of medical assessment: ▪ Individual #308 had an annual ISP dated 9/17/11. This individual was sent to the ER three times after that for vomiting and ileus/constipation. There were no follow up ISPAs submitted that addressed any of these ER visits. There was no evidence the team was aware of the ER visits, or met to discuss and begin to address the risk reduction. This individual had been hospitalized in 7/11 for similar symptomatology and found to have a fecal impaction. At that time, two additional medications were added to resolve the constipation. However, the ER visits that followed did not result in any diagnostic studies, such as EGD, colonoscopy, gastric motility studies, etc. At the time of the most recent annual meeting on 9/17/12, there was concern of weight loss. At that time, a gastric motility study was ordered, and was scheduled for 10/9/12, over a year from when his hospitalization occurred and after three additional health events requiring an ER visit. Further, the quality of the quarterly medical review was problematic, because the August 2012 review did not mention the 6/26/12 ER visit. A review of the medications indicated this individual was not prescribed any medication for potential gastritis, such as a proton pump inhibitor. Additionally, this individual was taking Alendronate that may contribute to gastritis or vomiting. Overall, there was no response from the IDT to the change of health status, although there were three opportunities to address change of status in 2012. There also appeared to be a delayed and incomplete assessment of the recurrent problems of vomiting, ileus, and constipation. ▪ Individual #242 was hospitalized three times in 2012, and had an additional ER visit once in 2012. For the ER visit of 8/21/12 for possible aspiration pneumonia, vomiting, and UTI, there was no ISPA submitted to indicate evidence that the IDT met to address this issue and the frequent ER/hospitalizations. This individual had several complex diagnoses, including Coumadin toxicity twice, one in 9/2012, at which time the specialist took the individual off of it. In the past, a specialist had determined the individual should have life long anticoagulation due to the risk of pulmonary embolism. The difficulty with adjusting dosage to a therapeutic level remained a challenge. There was no information as to whether a Greenfield filter was an option to reduce the risk of pulmonary embolism without the use of medication, a discussion that would have occurred at an ISPA. The individual had a history of mild dysphagia, and was taking nectar-thickened liquids. The last modified barium swallow (MBS) study was 2006. There was no information as to whether triggers were being followed, and if the individual was a candidate for a repeat study. There was a history of gastroparesis, and a history of chronic gastritis, but there was no	

#	Provision	Assessment of Status	Compliance
		information submitted concerning discussion of risks and benefits during an ISPA concerning the individual being prescribed Alendronate. In summary, there were several gaps in assessment that would have benefited from further documentation or evaluation. The individual had chronic UTIs, and had been placed on a topical therapeutic agent in 3/12, but still developed a UTI in 8/12. There was no discussion concerning whether this was considered a successful treatment in reducing the frequency of UTI, or whether there should be the commencement of another treatment that was mentioned in the annual exam, chronic suppressive therapy. There was no evidence that the team addressed the change in status within five days. ▪ On 7/17/12, Individual #45 was hospitalized for dehydration and constipation. There was no ISPA submitted to indicate the IDT completed a record review of this event to determine how dehydration could have been avoided, develop triggers for this problem, or address constipation on a long-term basis. There was the on going concern of medication refusals, and there was no ISPA submitted to indicate the IDT met to address this ongoing concern. The most recent submitted IRRF indicated the individual was low risk for fluid imbalance and moderate risk for constipation. No updated information was provided since the ISP of 11/16/11. Further behavioral and medical assessments might have been indicated, based on the limited information submitted. Other concerns that were noted included: ▪ Individual #147 has many medical diagnoses. On 6/17/12, this individual fell with injury, but there was no ISPA to address the event or review the risk of falling. This individual has had a work-up for anemia in 2012, which included upper and lower GI endoscopy. This individual also had been followed by cardiology for a history of pulmonary edema. Medical assessments were current. However, evidence of timely response from the IDT was not submitted. ▪ Individual #8 sustained a laceration from a peer pushing the individual down. This required an ER visit. The ISP of 6/7/12 indicated this individual had had several peer-to-peer aggression incidents in the prior 12 months. There was no ISPA submitted to indicate the IDT met to discuss how to prevent a recurrence. That apparent continuing peer aggression indicated the need for a thorough review of the incident. The current plan to avoid peer aggression was demonstrated to be inadequate to meet the individual's needs. There was no evidence that the IDT responded to the injury by creating an enhanced/revised ISPA. Medical assessments appeared up to date. ▪ On 6/11/12 Individual #2 had a stroke and was hospitalized. A feeding tube was placed. The prior annual ISP had been on 4/6/12. The individual had a follow up ISPA on 6/15/12, the date of return to LBSSLC. There was also discussion and change in risk ratings based on the change of health status.	

#	Provision	Assessment of Status	Compliance
		There were several extensive documents created by the PNMT, a PNMT pre-referral of 6/12/12 and 6/15/12, a PNMT referral of 6/21/12, and two PNMT reviews with the IDT on 6/28/12 and 7/12/12. Acute care appeared to be thorough and timely. IDT response and completeness of assessments were noted. ▪ Individual #9 had two hospitalizations. For each, there was an ISPA that addressed specific issues such as identifying triggers, need for deep cleaning of the home, and a review of the positioning schedule. Risk ratings were also reviewed. IDT response and completeness of assessments were noted. For five of the 12, ISPAs were not required. However, the following observation of progress in the quality of the IDT review was noted in one of five for whom there was no hospitalization or ER visits. Individual #181 was not hospitalized or sent to the ER in 2012. The IRRF recorded important details of each risk category and demonstrated the team understood the current diagnoses and risk problems. Triggers and action steps for direct support professionals and nursing were clearly identified. Assessments appeared to be current. Overall, the Facility remained challenged in providing evidence of timely response to change in health status. It is recommended that the Facility continue to refine the at-risk process to be able to track the time between IDT notification of change of status and development of the ISPA. However, there also needs to be tracking of steps taken based on the ISPA to determine the timeliness in obtaining additional assessments or toward implementation of a revised plan. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk,	Based on a review of 22 records for individuals determined to be at risk (i.e., Individual #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #276, Individual #160, Individual #74, Individual #235, Individual #94, Individual #220, Individual #52, Individual #204, Individual #232, Individual #136, Individual #164, Individual #312, Individual #183, Individual #178, and Individual #1), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none of the cases reviewed (0%). Although the Action Plans reviewed included a date of implementation, there was no supporting documentation verifying that	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	the action steps contained in the plan had in fact, been implemented. In addition, a number of the action steps were so nonspecific and generically written, it would not be possible to verify their implementation. ▪ 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%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage fluids or increase activity, which would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 14 of the cases (64%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #160, Individual #52, and Individual #204. ▪ 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. The significant problematic issues that resulted in noncompliance with the above compliance indicators included: ▪ The Facility indicated that there were no Risk Action Plans for some individuals who had high and/or medium health risk indicators; ▪ The Monitoring Team was unable to determine what information on the Integrated Risk Rating Forms was actually revised when changes in status had occurred, which in turn, made it impossible to determine if there had been appropriate and timely associated assessments or changes made to the Risk Action Plans; ▪ The Risk Action Plans that were reviewed generally were found to be generic, and non-specific in addressing the health risks of the individual; ▪ Specific and measurable preventative interventions were not consistently included in the Risk Action Plans;	

#	Provision	Assessment of Status	Compliance
		▪ Interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency included; ▪ Often the interventions listed on the Risk Action Plans were not in alignment with the designated risk rating of high or medium risks; and ▪ There was no supporting documentation indicating that interventions contained in the Risk Action Plans were actually implemented. In addition, general observations from the Monitoring Team regarding Section I that should assist in guiding the IDTs and in interpretation of the documents by all reviewers include the following: ▪ There needed to be a system to document timeliness of steps outlined in the Settlement Agreement (i.e., beginning the assessment process within five days, proof of implementation within 14 days, etc.). ▪ For several individuals, there should have been revisions of the IRRF and risk action plans in the past year in response to changes in status. It is important to differentiate new information (with date that paragraph or statement was updated) from prior information. ▪ Teams needed to clearly define the assessments being requested to create a final risk action plan. For most IRRF documents, it was difficult to determine if additional assessments were being requested, and when the request was made. This is especially important to identify the five-day time period in which the assessment process should begin. ▪ It would be helpful to have a chart at the end of the document listing the assessments with columns to indicate when it was requested, when it was completed, when it was received by the IDT, when it was discussed at an IDT meeting, and the date of the ISPA at which it was discussed and acted upon. ▪ The IRRF and risk action plan were inconsistent about including monthly/quarterly updates in the documents. There should be consistency across the campus about whether to include these in the reports or not. ▪ The ISPs did not appear to reflect the process for health status change, or the questions raised at the morning provider meeting that resulted in an IDT meeting followed by an ISPA. Documentation of the health status change and the effectiveness of any steps taken as a result of implementation of the ISPA would be expected to be part of a future ISP for that particular risk. For each hospitalization/ER visit, the goal would be to have a discussion about preventing a recurrence, with action steps that can be measured. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this provision. This was consistent with the findings of the Monitoring Team. Although the Facility was in the beginning stages of	

#	Provision	Assessment of Status	Compliance
		implementing a new pilot addressing the At-Risk system, it was concerning to note the inconsistent and fragmented documentation regarding the At-Risk individuals. These problematic issues made determining the chronological clinical sequence of events, and the Facility's response to these events confusing and complicated. Clear documentation, especially during revisions and changes in the At-Risk system is essential. LBSSLC should continue to focus its efforts on the process of appropriately rating health risks and developing specific and clinically appropriate risk action plans for each individual by the next review. These 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. PCPs should be encouraged to attend the risk rating meetings. They should be sufficiently prepared to discuss the work-ups or completed aspects of the work-up, interpret lab and test results for the IDT, provide details regarding the history as well as current health status of the individual, and recommend next steps. They should play an instrumental role in assisting the team to finalize measurable objectives and determine clinical indicators for each of the high and medium risks for the individual. (Sections I.1, and I.2)
2. 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)
3. Additional training and/or technical assistance 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)
4. 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)
5. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. Additionally, for those members of the team unable to attend an IDT risk rating and/or action plan meeting, background information should be prepared and discussed with the QDDP ahead of the scheduled meeting and the QDDP or designee should ensure all areas needing clarification are discussed and clarified, as the QDDP or designee will be the team member presenting that information. (Section I.1)
6. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
7. 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)
8. 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)
9. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines.

(Section I.2)

10. Given that IDTs, at times, do not realize when more assessment is indicated, and department heads should review IDTs' findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
11. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it. (Section I.3)
12. 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)
13. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Facility 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)
14. Regarding the Facility's monitoring system addressing Section I, the Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. (Facility Self-Assessment)
15. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation, using, for example, tables to report monitoring findings rather than a narrative format that would be better for the presentation of the analysis of the data. (Facility Self-Assessment)

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Agenda and supporting materials from the 10/2/12 Pharmacy and Therapeutics (P&T) Committee Meeting; o Alphabetical list of individuals psychiatrically hospitalized during the last year; o Reiss Screening instrument spreadsheet as of 10/1/12; o Reiss Screening Score Sheets and reports for Individual #185, dated 7/11/12, and Individual #56, dated 7/9/12; 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 Examples of recent Behavioral Desensitization Plans for dental/medical appointments for ten individuals; o Policy for psychiatric assessments, dated 9/1/08, and revised 3/5/12; o The following documents that were in the Presentation Book related to Section J of the Settlement Agreement, dated August 2012: • 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 September 2012; o Spreadsheet of Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations completed through September 2012; o Restraint Report for LBSSLC for the last six months; o List of individuals prescribed intra-class polypharmacy; o List of individuals monitored for tardive dyskinesia; o List of individuals prescribed an anticonvulsant medication for psychiatric reasons; o List of meetings and rounds attended by the psychiatrists, undated;

	o Curriculum vitae (CV) of Richard Weddige, M.D.; o CV of Boris Porto, M.D.; o CV of Shiraz Vahora, M.D.; o Overview of psychiatrists weekly schedule, undated; o Job description of Psychiatrist III, undated; o Minutes, supporting documents, and attachments for the "Monthly Facility Review of Psychoactive Medication Polypharmacy" Meetings, for the past six months; o Documents related to the 10/4/12 Meeting of the Desensitization Committee; o 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 Problems List; Hospital Admission section; Health Risk Assessment Rating, including tool and team meeting sheet (only most recent); Psychiatry section including 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.]; and 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 #300, Individual #34, Individual #92, Individual #127, Individual #193, Individual #68, Individual #131, Individual #232, Individual #259, and Individual #273; o The same set of records was requested during the onsite review for the following individuals due to their clinical acuity: Individual #33, Individual #27, Individual #25, Individual #318, Individual #7, Individual #82, Individual #146, Individual #154, and Individual #299; o Chemical restraint documentation for the episodes listed below where chemical restraint (and the dates of restraint) was administered: Individual #299 (6/10/12 and 6/11/12), Individual #36 (4/30/12), Individual #7 (4/30/12), and Individual #320 (4/2/12); o Documentation for individuals administered pre-treatment sedation medication (and the dates of administration): Individual #310 (5/9/12), Individual #51 (4/12/12), Individual #284 (8/1/12), Individual #184 (5/22/12), and Individual #267 (5/10/12); o List of individuals who received medical pre-treatment sedation medication: 3/1/12 to 10/1/12; o List of "Oral Sedation Medication Given for Dental Appointments – Reporting Dates: 3/1/12 to 10/1/12;" o Spreadsheet maintained by the Psychiatry and Psychology Departments to track the development of Desensitization Plans, as of 10/2/12; o Spreadsheet of individuals listing the status of CPA completion, through September 2012; and

	○ MOSES/DISCUS side effect scales for the following five individuals who were prescribed Reglan: Individual #323, Individual #136, Individual #199, Individual #74, and Individual #176. ▪ **Interviews with**: ○ Dr. Richard Weddige, Director of Psychiatry, on 10/1/12, 10/2/12, 10/3/12, and 10/4/12; ○ John McCullen, Psychiatry Assistant, on 10/1/12 and 10/4/12; ○ James Forbes, Director of Psychology Services, on 10/1/12; ○ Dr. Russell Reddell, Director of Dental Services, on 10/1/12; ○ John Todd, R.PH., Clinical Pharmacist, on 10/1/12; ○ Glen Shipley, D.O., Medical Director, on 10/1/12; ○ Boris Porto, M.D. (by telephone), on 10/1/12; ○ Shiraz Vahora, M.D., on 10/2/12; ○ Sheila Powell, Human Rights Officer, on 10/3/12; and ○ John McCollum, Psychiatry Assistant; Bob Robbins, Program Compliance Monitor; and Dr. Richard Weddige, on 10/2/12. ▪ **Observations of**: ○ Polypharmacy Committee Meeting, on 10/3/12; ○ Morning Provider Meeting, on 10/2/12; ○ Pharmacy and Therapeutics Committee Meeting, on 10/2/12; ○ Human Rights Committee Meeting, on 10/3/12; ○ Psychiatric Clinics at 526 North Cedar, on 10/2/12; ○ Neurology Clinic with Dr. Daniel Hurst, on 10/3/12; ○ Desensitization Committee Meeting, on 10/4/12; ○ ISP Meeting for Individual #140, on 10/4/12; and ○ During visits to the residences and day/vocational programs at LBSSLC, the following individuals were observed: Individual #156, Individual #274, Individual #26, Individual #146, Individual #299, Individual #318, Individual #167, Individual #284, Individual #99, Individual #213, Individual #1, Individual #82, Individual #202, Individual #300, Individual #155, Individual #50, Individual #82, Individual #86, Individual #233, Individual #45, Individual #174, Individual #315, Individual #306, Individual #317, Individual #79, Individual #184, Individual #298, Individual #242, Individual #143, Individual #108, Individual #140, and Individual #25.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 8/17/12. In its Self-Assessment for each subsection, 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. The documents assembled in the Presentation Book indicated the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. On 10/2/12, during the onsite review, these materials, including the Facility Self-Assessment, 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 an audit of all five, and the Program Compliance Monitor also reviewed all five records. An assessment of inter-rater reliability, based on these two independent reviews, was performed on all five reviews. This monthly process resulted in 60 reviews per year, or slightly less than one-half of the individuals prescribed psychotropic medication. The data generated was reviewed quarterly in the Facility's QA/QI meeting, and discussed monthly with the Psychiatry Department. In order to become more familiar with the clinical aspects of psychiatric care and to assist him in appropriately performing the QA review of an individual's psychiatric record, the Program Compliance Monitor attended the Psychiatric Polypharmacy Meetings, as well as the Behavior Support Committee Meetings. The following narrative discusses specific elements of the Facility Self-Assessment.

For Section J, in conducting its self-assessment:

- The Facility used monitoring/auditing tools:
  - The monitoring/audit tools the Facility used to conduct its self-assessment included: the "Section J – Psychiatric Care and Services Monitoring Tool," which the DADS State Office of finalized on 8/8/12. However, LBSSLC began to use what was a near final draft of the document in April 2012.
  - This monitoring/audit tool included a number of indicators to facilitate the Facility's assessment of their progress toward compliance with the Settlement Agreement. Specifically, the instrument included a total of 39 indicators, which collectively addressed all of the 15 provisions of Section J. However, these indicators primarily assessed only the presence or absence of specific items and did not adequately address the important factor of quality.
  - The monitoring tools included adequate methodologies, which consisted of the review of 60 records per year (49% of the individuals receiving psychotropic mediations) by two independent reviewers, with an assessment of inter-rater reliability.
  - The Self-Assessment identified the sample(s) sizes, including the number of individual records reviewed, in comparison with the number of individual records in the overall population (i.e., 49% over a one-year period). These sample sizes were adequate to consider them representative samples.
  - The audit tools contained limited instructions and guidelines to promote consistency in monitoring and the validity of the results. As noted above, the Program Compliance Monitor regularly attended both the monthly Polypharmacy Committee Meeting as well as the Behavior Support Committee. He also participated in the monthly review of the results of the audit that was conducted by the Psychiatry Department, which was moderated by the Director of Psychiatry. These efforts greatly increased the ability of the Program Compliance Monitor to assess the necessary items in the individual records. However, the tool was not constructed in such a manner as to stand alone in this regard, and it would be difficult for a different individual who did not have this experience to

	effectively utilize the tool. o The following professionals were responsible for completing the audit tools: The Program Compliance Monitor and the Psychiatry Assistant, with the oversight of the Chief Psychiatrist. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). However as noted above this observation is specific to the current Program Compliance Monitor and the Psychiatry Assistant who performed these reviews. It is not clear that the tool would provide adequate guidance to another individual who did not have this experience. o With regard to inter-rater reliability, in general, the method the Facility used appeared to consist of simply comparing the results of the two different ratings to ascertain to what degree they were in agreement. However, any disparities between the results obtained by the two reviews were not discussed in the Facility Self-Assessment. ▪ LBSSLC used other relevant data sources to augment its monitoring activities. The additional sources of data primarily consisted of the comprehensive databases and spreadsheets used track the Facility's progress in the completion of documentation needed to fulfill various sections of the Settlement Agreement. The primary examples of this were the Reiss Screen spreadsheet (as discussed with regard to Section J.7), the Desensitization Program status-tracking spreadsheet; the MOSES/DISCUS completion-tracking spreadsheet (as discussed in relation to Section J.12), and the CPA completion database. The latter spreadsheet specifically related to Sections J.2 and J.6, but also indirectly related to several other provisions. ▪ In some ways, the Facility consistently presented data in a useful way. However, problems were noted. The following summarizes the positives and negatives: o On a positive note, the Facility Self-Assessment consistently presented the Facility's findings in a simple, straightforward "yes/no" dichotomous manner, with the exception of the spreadsheets alluded to above, where the results were reported as completion rates, which were then translated into percentages. o Of concern, the reviews primarily focused on the presence or absence of items, and not the quality of the documentation. For example, the reviews checked for the presence of the psychiatric diagnosis, the consistency of the diagnosis that was listed in different sections of the individual record, as well as if there were symptoms listed to support the diagnosis. However during the onsite interview they indicted they did not check with reference material to ensure that the diagnosis met all of the necessary criteria for that diagnosis. o The Facility did not distinguish data collected by the QA Department versus the Psychiatry Department. The work of the QA Department for Section J. was completely integrated in the self-assessment process of the Psychiatry Department. As indicated in the narrative description of the process above, the Program Compliance Monitor for Psychiatry worked closely with the Psychiatry Assistant and the Director of Psychiatry throughout the year. This individual also attended selected meetings of the Psychiatry Department to familiarize himself with the psychiatric treatment process at LBSSLC. In reviewing the individual sections of the Self-Assessment, it became clear that the Facility primarily relied

	on their databases/spreadsheets. The only sections in which the results of the internal audits were discussed to a significant extent were Section J.3, Section J.14, and Section J.15. For the other provisions, the Facility primarily relied on a spreadsheet/database, specific to that provision, or the completion rate of the CPAs, as content of CPAs relates directly or indirectly to many of these provisions. In many cases, this was inadequate, because record reviews were necessary to determine the quality and completeness of the assessments and other documentation. ▪ The Facility rated itself as being in substantial compliance with the following subsections of Section J: Sections J.1, J.2, J.6, J.7, J.11, J.12, J.13, and J.15. These findings were consistent with those of the Monitoring Team, with the exception of Section J.5, for which the Monitoring Team found the Facility to be in substantial compliance, while the internal self-assessment did not. Section J.5 is a relatively straightforward provision, which primarily requires a sufficient number of Psychiatrists to effectively provide treatment to the individuals residing at LBSSLC who require psychiatric treatment. The reason for the discrepancy in the findings appears to relate to the timing of the two separate reviews and the addition of psychiatry services in the interim. The Monitoring Team's finding are discussed in detail with regard to Section J.5. ▪ The Facility Self-Assessment identified areas where more improvement was needed. This observation was true for all of the provisions for which the Facility Self-Assessment indicated a current status of noncompliance. In the Self-Assessment, the Facility provided some limited description of actions it believed might result in improvements (e.g., implementation of the new ISP process). In summary, the Psychiatry Department was actively engaged in the process of self-assessment, and worked closely with the QA/QI Department. The only aspect of the self-assessment processes the Psychiatry Department performed independently of the QA/QI Department was the development and maintenance of the aforementioned specific databases. However, the Facility did not rely on the results of this internal monitoring to the degree that would have been anticipated. Instead, they appeared to rely almost entirely on the completion rate of the CPAs for provisions for which the results from their QA system would also have been useful.
	Summary of Monitor's Assessment: The Facility recently had added a new full-time Psychiatrist, who was going through the orientation process at the time of the Monitoring Team's review. 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 122 individuals who received psychotropic medication at LBSSLC. This analysis also took into account the support staff, which included a Psychiatry Assistant and a newly added Psychiatry Clerk. The current full-time Psychiatrists and the part-time Consulting Psychiatrist were all Board Certified. The Facility clearly had responded to the recommendations made in the Monitoring Team's previous report. This was evident in the progress in relation to many of the 15 provisions of Section J of the Settlement Agreement.

	At the time of the Monitoring Team's previous review, the Psychiatry Department had revised the content of the Comprehensive Psychiatric Assessments to better conform to the requirements of the Settlement Agreement. At the time of the current review, the Facility reported they had been completed for 100% of the individuals prescribed psychotropic medications. With two full-time Psychiatrists, and the Consulting Psychiatrist continuing on four hours per week to assist with the CPAs, it should be possible to update these on an annual basis for all of the individuals who receive psychotropic medication. On 10/4/12, a member of the Monitoring Team attended the Desensitization Committee Meeting. At the time of the previous review, the Psychiatry Department had developed a system to facilitate the timely completion of the various steps in this process, which subsequently had been implemented. At the 10/4/12 meeting, the Behavioral Services Department reported that "Skill Acquisition Plans" had been completed for all of those individuals who require them for medical or dental procedures, and these plans were in various phases of implementation. In July 2012, the Psychology Department also had administered the Reiss Screen to all of the individuals not receiving psychotropic medication. 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. It will be important to fully document the contribution of Psychiatry to the ISP process. While on site, 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 psychiatric contributions to the ISP process should be indicated clearly in the final ISP documentation. 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. This gave the impression the medication was being used to suppress a learned behavior. The Psychiatry Department had responded to this with thorough discussions in the CPAs and elsewhere in the records, and the Department of Behavioral Services now had added a discussion to address this in the Functional Analysis. These interventions had effectively addressed this problem. Progress regarding reductions in polypharmacy continued. The Psychiatry Department had created three subcategories based on comments 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 individuals whom teams believed required their existing medication to maintain their stability. The importance of assembling as much empirical evidence as possible to document the efficacy of these medications was discussed at the time of the previous review. The Facility had responded to this recommendation by assembling empirical historical data to substantiate the efficacy of the medication for the individuals they believed required continuation of their medication. The third category was labeled, "New Admissions," and tracked the progress of the individuals who had been admitted from the community on multiple psychotropic medications.

	In summary, LBSSSLC had made progress in a number of areas related to Section J. This progress, as well as areas that will require continued attention, are discussed in the report that follows.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Richard Weddige, Director of Psychiatry, was Board Certified in Psychiatry by the American Board of Psychiatry and Neurology. He served on the Faculty of Texas Tech University Health Sciences Center School of Medicine, Department of Psychiatry, full-time for 27 years. He retired in 2001. Following his retirement from the faculty, he began consulting to LBSSLC on a part-time basis, and had worked full-time at the Facility for the last eleven years. Prior to the previous onsite review, the Facility had contracted with Dr. Boris Porto to provide additional psychiatric services. His Curriculum Vitae indicated 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 at LBSSLC through a four-hour block of time on Fridays. He performed second-opinion consultations for Dr. Weddige, and general consultations as the need arose. At the time of this onsite review, however, his primary role was to contribute to the initiative to complete and update Comprehensive Psychiatric Assessments. In the course of preparing these documents, he performed a review of the records and met with the individual, as well as members of the individual's team during his observation in the residences, and the day and vocational programs as well. He was also following (on a weekly basis) Individual #47, who was recently admitted to the Facility and presented with a complex psychiatric disorder. On 10/1/12, a member of the Monitoring Team interviewed the consulting psychiatrist (by telephone). Dr. Porto indicated that he had several years of professional experience working with individuals with intellectual disabilities/developmental disabilities (ID/DD) through his contracts with group home providers in the community. He had maintained such contracts for well over 10 years as part of his office-based private practice. LBSSSLC recently was able to hire a new full-time Psychiatrist, Shiraz Vahora, MD. At the time of the Monitoring Team's onsite review, he was in the process of completing his pre-service orientation. Dr. Vahora was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, and also had taken the additional examinations for certifications in the sub-specialties of both Geriatric and Forensic Psychiatry. During the Monitoring Team's 10/2/12 interview with Dr. Vahora, he indicated that he had worked in correctional psychiatry for the last several years. However, during this time, he also	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		continued to work on a part-time basis for the state Mental Health/Mental Retardation (MH/MR) clinic system. Specifically, the correctional work was scheduled so that he would be able to fulfill the requirements of that job in four days, and then would have Fridays to work with patients through the MH/MR system, many of whom had ID/DD and comorbid psychiatric disorders. The Facility remained in substantial compliance with this provision. The American Board of Psychiatry and Neurology had certified all of the Psychiatrists who provided clinical services to the individuals who resided at LBSSLC, and all had relevant experience with individuals with ID/DD.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At LBSSLC, a total of 122 individuals were prescribed psychotropic medication. A sample of individuals was selected for the current review, as described in the section above listing the documents reviewed. This included 19 individuals, or 16% of those prescribed psychotropic medication. As noted above, at the time of the review, the Psychiatrists who diagnosed and treated the individuals 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 prescribed psychotropic medication. The consulting psychiatrist played a large role in the completion of the CPAs. During the Monitoring Team's interview with him, the consulting psychiatrist clarified that his process for completing the CPAs involved a thorough review of the individual's clinical record, including any prior CPAs; observation of the individual at his/her residence and/or program site; and discussions with members of the IDT. The process by which the Psychiatrist interacted with the team and interviewed/observed the individual is detailed in relation to Section J.13. The Department of Psychiatry maintained data related to its progress in completing the CPAs for those individuals who received psychotropic medication. Review of this spreadsheet entitled: "Psychiatric Assessments (Active List)," indicated that an updated	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		CPA had been completed for all of the individuals who were prescribed psychotropic medication (100%). This showed improvement from the 77% completion rate (97 of 126) reported in the Facility's Self-Assessment of 3/23/12, and the 43% (54 of 126) reported in the 1/25/12 Report. The review of the records of 19 individuals prescribed 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 (95%). The only exception was the CPA for Individual #34. Although the CPA of this individual met the standards of the Settlement Agreement, the most recent update was dated 8/9/11. The spreadsheet included a column for the most recent date that a revised CPA was performed. There were a few other individuals identified on the spreadsheet who were overdue for an updated annual CPA. This will be discussed with regard to Section J.6, which also reviews the process for completing the CPA. 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. The current review indicated that the psychiatric diagnosis for all of the 19 individuals (100%) in the sample, which represented 16% of the individuals prescribed psychotropic medication, contained adequate documentation to justify their psychiatric diagnosis. The Facility utilized the diagnostic nomenclature published in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revised* (*DSM-IV-TR*). The description of the symptoms in the three primary sources where the diagnosis was discussed (i.e., CPAs, Quarterly Review, and Psychiatric Consultation) were sufficient to meet the standards for the diagnoses. The Facility did not utilize the "Rule-Out" or "Deferred" terminology to qualify a specific diagnosis as being incomplete or atypical. There were no changes in psychiatric diagnoses over the last six months. However, if alternate diagnostic considerations were plausible, based on the individual's presentation, the "Bio-Psycho-Social-Spiritual Formulation" of the CPA listed alternate possible diagnoses that were considered as part of the differential diagnosis discussion. The Monitoring Team's previous reviews had identified a significant problem related to the identification of behaviors that were listed as "targets" of psychotropic medication in the Quarterly Psychiatric Reviews, and then being attributed to environmental and/or behavioral factors in the Psychology section of the individual's record. The Psychiatry Department, working in conjunction with the Department of Behavioral Services, had effectively addressed this problem through the systemic methods discussed in detail	

#	Provision	Assessment of Status	Compliance
		with regard to Sections J.8 and J.9. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement. Based on the sample of records reviewed, a Psychiatrist certified by the American Board of Psychiatry and Neurology had diagnosed each individual prescribed psychotropic medication. Based on the sample, the individuals had been appropriately diagnosed, and the diagnostic material was found to meet the standards set forth in the Settlement Agreement. To maintain compliance, the Facility will need to ensure timely annual updates of the CPAs.	
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 Psychiatric Clinics, as well as the review of the records of 19 individuals prescribed 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. A member of the Monitoring Team was able to directly observe 32 individuals prescribed psychotropic medications (26%). These observations did not reveal any individuals who appeared to be overly medicated, sedated, or displaying obvious side effects. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication was present for all of the individuals in the sample of 19 individuals and is discussed in more detail with regard to Sections J.2, J.6, and J.13. The 19 records that were reviewed indicated that there was an active Positive Behavior Support Plant (PBSP) for each individual who was prescribed psychotropic medication. The Monitoring Team's previous reports noted that the behaviors that were identified as the "target behaviors" of the psychotropic medication also were frequently identified in the Structural and Functional Assessment Report and related PBSP as being present on a behavioral basis and/or related to environmental factors. 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. Through active collaboration between the Psychiatry and Psychology Departments, as discussed below with regard to Sections J.8 and J.9, this problem had been eliminated in the clinical documentation of the records of 19 individuals (16% of those receiving psychotropic medication). Concerns related to the quality of PBSPs are discussed with regard to Section K.9 of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 utilization 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 #299	6/11/12	11:40 p.m.	Ativan 2 milligrams (mgs); Haldol 5mgs, and Cogentin 1mg IM
Individual #299	6/10/12	8:40 a.m.	Ativan 2mgs IM
Individual #36	4/30/12	9:00 a.m.	Ativan 2mgs (route not specified)
Individual #7	4/30/12	8:25 p.m.	Ativan 2mgs IM
Individual #320	4/2/12	7:17 p.m.	Ativan 2mgs (route not specified)

The restraint data was reviewed for the presence and quality of the five 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:

- 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 (100%). However, the documentation for Individual #36 and Individual #320 indicated that these individuals were aggressive and agitated prior to this, but did not describe the specific antecedent events. The face-to-face debriefing section of the incident involving Individual #36 did contain an adequate discussion of the antecedent events.

  However, this was not the case for Individual #320, because additional documentation did not convey a clear description of the factors that might have precipitated the incident. The Psychology section of this documentation suggested retraining the direct support professionals on the proper administration of the individual's PBSP, and also further in-service for the Security personnel involved. This degree of diligent follow-up indicated that the Facility was paying close attention to these events. However, it also suggested that this incident could have been responded to in a more appropriate manner.

#	Provision	Assessment of Status	Compliance
		In addition to the documentation issue, there were also significant problems in the appropriate implementation of the BSP that could have led to physical injury and also suggested that the entire incident might have been avoided if the staff had been provided with the necessary training. Based on this review of the quality of the documentation, for four out of five incidents of chemical restraint (80%), adequate descriptions of the events leading to the restraint were provided. ▪ 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. Thus, the documentation was completed adequately for all five individuals (100%). ▪ The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for all of the individuals in this sample (100%). ▪ The face-to-face post-restraint debriefing was completed for all five individuals (100%). ▪ The Chemical Restraint Clinical Review Form was completed for all five of these individuals in a timely manner (100%). Thus, these essential elements of the documentation needed to verify the appropriate utilization of chemical restraint were fully completed for three of the five individuals (60%) in this sample. Taking into account that the face-to-face debriefing for Individual #36 did describe the antecedent events more effectively than the initial description by the direct support professional would increase this percentage to 80%. 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. The Facility had made substantial progress in the extremely important area that prompted 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 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 chemical 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	

#	Provision	Assessment of Status	Compliance
		administrations of chemical restraint, was that of Individual #320, for whom this section only described the overt behavior that precipitated the chemical restraint. However, as noted above the documentation that was available for this incident indicated that there were potentially serious issues in the conduct of this intervention. The Facility remained in noncompliance with this provision, due to the aforementioned deficiencies in the documentation of the chemical restraint process. This finding should not be construed as implying that the use of psychotropic medication at LBSSLC is utilized on a routine basis for the convenience of staff, or as punishment, as there was no overt evidence to suggest that this was occurring. The finding is based on the finding that the documentation in the Chemical Restraint data is not uniformly sufficient to ensure that there are not instances where chemical restraint may have been inappropriately utilized. The face-to-face debriefing section of the restraint documentation, which is completed by the Psychologist, would appear to be one place where any inadequacies in the description of the event by the direct support professionals could be rectified. The follow-up Post-Chemical Restraint Review by the Psychiatrist provides another such opportunity to ensure that the documentation provides a clear description of the antecedent events and documented the clinical rationale for the intervention.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Human Rights Officer maintained a comprehensive spreadsheet concerning the use of pre-treatment sedation. This document listed all individuals prescribed pre-treatment sedation, and 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 current version of this document was dated 10/1/12. The total number of individuals listed on this spreadsheet was 125 of the total LBSSLC census of 211 individuals (59%). All but six of these individuals had a notation that they had a Rights Restriction for dental sedation. Within the group requiring sedation for dental procedures, 41 had a specific notation for consents for IV and/or general anesthesia. Pre-treatment sedation for medical procedures was required for 29 individuals. Only four individuals were listed as requiring pre-treatment sedation for medical procedures, but not also for dental procedures. The total of these numbers 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		not noted on the spreadsheet, and, thus, the numbers cited above could not be mathematically reconciled. During the onsite review, a request also was made for the actual utilization data regarding the use of pre-treatment sedation for the last six months. The data that was presented in response to this request was entitled "List of individuals who received medical pre-sedation – 3/1/12 to 10/1/12." The document listed 45 individual administrations of medication for medical procedures, including 26 unique individual names. Pre-treatment sedation administrations for specific individuals during this six-month timeframe ranged from one to three. Five individuals received pre-treatment sedation on three separate occasions during this timeframe, eight received two, and the remainder only received one. The most frequently utilized agents were Ativan and Zyprexa. Ativan was prescribed for 14 of the 45 administrations (31%) with one or two milligrams given either by mouth (PO), IM, or per gastrostomy tube (G-tube.) There were 21 administrations (47%) of Zyprexa or Zydis (Zydis is the rapidly dissolving sublingual form of Zyprexa), in the range of 5mgs to 10mgs either PO or IM. The remainder of the individuals received either: Haldol 5mgs PO; Benadryl 25mgs PO, and Ativan 2mgs (in combination); or, Buspirone 20mgs PO or Benadryl 50mgs; or Mellaril 75mgs PO. The frequency of the use of the latter medications was in the low single digits for each. A similar request was made for the data related to the utilization of pre-treatment sedation for dental procedures during the same prior six-month period. The document that was presented in response to this request was entitled "Oral sedation given for dental appointments reporting dates: 3/1/12 – 10/1/12." This document contained a list of six unique individuals who each received one administration of pre-treatment sedation for dental procedures during this time period. All of the orders were for Ativan 2mgs (except one for 3mgs), given two hours prior to the appointment. The route of administration was not identified on the spreadsheet. 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. At the time of the Monitoring Team's previous review, the Psychiatry Department had begun tracking individuals administered 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. The Psychiatry Clerk maintained and updated this database weekly. It was also reviewed during the 10/4/12 Meeting of the Desensitization Committee, which was	

#	Provision	Assessment of Status	Compliance
		a member of the Monitoring Team attended. Following this meeting, a member of the Monitoring Team also reviewed this information with the member of the Psychiatry Department who maintained this data. The spreadsheet prepared for this meeting indicated the Psychology Department, working in conjunction with Dental Services, had identified 101 individuals who could benefit from Skill Acquisition Plans to help them cooperate with dental procedures. It also indicated all of these plans had been developed and were in various stages of implementation. The corresponding number of individuals identified as suitable candidates for pre-treatment sedation for medical procedures was 26, and Skill Acquisition Plans also had been developed for all of these individuals. The quality of these plans is discussed with regard to Section C.4 of this report. The "Medical/Dental Restraint Checklist" (previously referred to as the "Pre-sedation Assessment") consisted of 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 all information the Facility considered relevant to 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 initialed 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 five recent instances of the administration of pre-treatment sedation medication revealed the following: ▪ On 5/9/12, Individual #310 received pre-treatment sedation medication (Ativan 2mgs PO) for a dental examination. Review of the related information indicated the Psychiatrist, Pharmacist, Medical Provider, and the Medical Director had completed and initialed all relevant sections in a timely manner. ▪ On 4/12/12, Individual #51 received pre-treatment sedation medication (Ativan 3mgs IM) for a routine oral examination. All of the specified sections of the document packet had been completed, as well as the Pharmacist, Medical Provider, Medical Director, and Psychiatrist's reviews. ▪ On 8/1/12, Individual #284 was administered pre-treatment sedation medication (Ativan 2mgs PO) for dental prophylaxis and treatment. All sections of the document packet were completed, as well as the Pharmacist, Medical Provider, Psychiatrist, and the Medical Director's timely review. ▪ On 5/22/12, Individual #184 received pre-treatment sedation medication (Ativan 2mgs PO) for a dental prophylaxis. The relevant sections were	

#	Provision	Assessment of Status	Compliance
		completed, and the initials of the Pharmacist, Medical Provider, Medical Director and Psychiatrist were present, and had been obtained in a timely manner. ▪ On 5/10/12, Individual #267 received pre-treatment sedation medication (Ativan 2mgs PO) for a dental prophylaxis. The physiological monitoring and corresponding narrative section of the documentation was present, but the page that contained the initials of the professionals identified above denoting their review of this documentation was absent. As indicated above, the five most recent packets of information related to the use of pre-treatment sedation for dental procedures, showed significant improvement, compared to the results of the prior review. At the time of the Monitoring Team's previous review, the Psychiatry Department had assumed responsibility for ensuring that these documents were completed according to the Facility's specifications. At that time, the systemic intervention the Facility had implemented to effectively address this problem involved having each administration of pre-treatment sedation medication reviewed at the following day's morning meeting, because all of the disciplines responsible for reviewing and initialing the related documentation attended this meeting. Although the Facility had made considerable progress in meeting the requirements of this provision of the Settlement Agreement, they remained in noncompliance. A significant number of Desensitization Plans had been developed for dental procedures, but the Facility was still in the early phases of implementation. The process to develop Skill Acquisition Plans for medical procedures was progressing, but was not as far along in execution as the Dental Plans.	
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.	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 CPAs, 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. He concluded that two full-time Psychiatrists should be sufficient to provide services to the individuals who received psychotropic medication at LBSSLC. As indicated in the comments concerning Section J.1, at the time of the review, LBSSLC employed two full-time Psychiatrists. A total of 122 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 61 individuals. The Facility continued to employ the part-time Psychiatrist that had been added for four	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. The Facility also had created a new position for a Psychiatry Nurse Practitioner who, under Texas regulations, could practice in conjunction with a Psychiatrist. The Facility had recruited an individual who recently completed all of the necessary certifications, and had indicated an interest in beginning to work at the Facility in January. In addition to the Staff Psychiatrists, the Facility also employed one full-time Psychiatry Assistant to help coordinate the psychiatric care of the 122 individuals prescribed psychotropic medication. The Facility also had recently added a full-time Psychiatry Clerk to assist with the data collection. Thus, the total composition of the Psychiatry Department at LBSSLC would appear to provide sufficient resources to meet this requirement of the Settlement Agreement. 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.	
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 19 individuals receiving psychotropic medication identified a completed CPA for all of the 19 individuals in the sample that met the formatting requirements specified in the Settlement Agreement (100%). However, timely CPAs, which had been completed within the last year, were found for 18 of these 19 individuals (95%). The only record that did not contain a current CPA was that of Individual #34, for whom the most recent CPA had been completed on 8/9/11. This information was verified by cross-referencing the information in the individual's record with that contained on the master spreadsheet the Facility maintained. The information on the spreadsheet related to the completion of CPAs was consistent with that contained in the individual records reviewed. At the time of the Monitoring Team's previous review, the Facility had revised the format of the CPAs to ensure it was consistent with the format specified in the Settlement Agreement. At that time, the Facility also changed the title of the CPA from the "Comprehensive Psychiatric Assessment" to "Revised Comprehensive Psychiatric Assessment" to clearly differentiate these newly formatted CPAs from the older ones that did not contain all of the content set forth in the Settlement Agreement. All of the CPAs going back to 2007 were maintained at the beginning of the Psychiatry section of the individuals' records, and were stamped to indicate they were not to be purged from the records. Eighteen of the 20 individuals (90%) reviewed in the Monitoring Team's	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		previous review also had CPAs that met the standards of the Settlement Agreement. In the prior review sample one record did not contain a CPA and another contained a diagnostic discrepancy. Thus, the CPAs that the Facility had designated as "Revised," met the specifications of the Settlement Agreement, and have been consistently determined to meet the criteria for two review cycles. The spreadsheet the Facility maintained to track the status of the completion rate of the CPAs, dated 9/10/12, identified 132 individuals, which exceeded the current number of 122 individuals receiving psychotropic medication. However, there had been individuals who were discharged into the community; and others who had been removed from psychotropic medications altogether. The exact reason why the number of the CPAs on the spreadsheet was greater than the number of individuals prescribed psychotropic medication was not specifically determined. The spreadsheet indicated there were five individuals for whom an updated annual CPA was overdue. These five individuals were as follows (date of most recent CPA): Individual #60 (8/11/11); Individual #137 (6/1/11); Individual #34 (8/9/11); Individual #298 (7/5/11); and Individual #291 (9/30/11). Given the most recent number of 122 individuals receiving psychotropic medication as of 10/5/12, this would indicate that the timely completion rate of CPAs was 96%. Accordingly, LBSSSLC was found to be in substantial compliance with this provision. Based on the representative sample of records reviewed during both the current review as well as the prior review discussed above, which indicated that the revised CPAs met the specifications of the Settlement Agreement. In addition, based on data the Facility provided, CPAs had been completed within the past year for 96% of the individuals prescribed psychotropic medication at the Facility.	
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	The Monitoring Team's previous reviews indicated the Reiss Screenings were first administered in the 2008 to 2009 timeframe, and had not been updated. This Settlement Agreement provision requires 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 previous review, a member of the Monitoring Team discussed these potential occurrences with the Director of Psychiatry as situations that should prompt the use of a Reiss Screen and possibly a CPA, depending on the results of the Reiss. At the time of the Monitoring Team's previous onsite review, the Facility did not use	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	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 would need to be utilized and this was recommended at the time of that review. During the interview with the Director of Behavioral Services he indicated that following the prior review, the Facility had decided to administer the Reiss Screen to all individuals residing at LBSSLC not prescribed psychotropic medication. As this would involve the administration of the screening instrument to a large number of individuals, they also decided to use the commercial computer scoring system. The spreadsheet, which was scanned on 8/30/12 in preparation for this review, indicated that in the month of July 2012, the Reiss Screen instrument was utilized to assess the behavioral status of such individuals. Specifically, this document indicated that during the month of July 2012, 88 individuals were evaluated with the Reiss. The Psychologist assigned to the individual administered the Reiss Screen instrument. The census of the Facility at the time of the Monitoring Team's current review was 211, of which 122 were prescribed psychotropic medications. This would suggest that there were 89 individuals who should have been screened. However, the Facility's census is subject to change, as is the number of individuals prescribed psychotropic medications due to discharges to and admissions from the community. Accordingly, most, if not all individuals not receiving psychotropic medication were evaluated. The Facility should cross-reference the current census list with the list of individuals evaluated or prescribed psychotropic medication to ensure no one was missed. LBSSSLC elected to utilize the commercially available computer screening to exclude the possibility of inaccurate individual scoring by the Psychology staff. The computer scoring also would have rejected or flagged documents that could not be scored because they were incomplete. The computerized scoring did not report any scores above the clinical cut-off score of nine that would have required further psychiatric assessment with a CPA. The Scoring Report for Individual #56, dated 7/9/12, reported a cluster of "avoidant" behaviors (raw score of 5). However, discussion with the individual's Psychologist had indicated this was consistent with his developmental status, and neither the scoring document nor the corresponding report identified any aggressive, self-injurious behavior, or symptoms of major mental illness that would have warranted further assessment. The report for the Reiss Screen administered to Individual #185, administered on 7/11/12, reported a cluster under the "Autism" category, which was consistent with the diagnosis of the Psychology Department. The report was also positive for a few items related to self-injury. This individual was already known to the Psychiatry Department, because they	

#	Provision	Assessment of Status	Compliance
		had informally discussed his self-injurious behavior with his parents. The Staff Psychiatrist indicated the parents had been adamant about not consenting for either a formal psychiatric assessment and/or the use of any psychotropic medication. The Psychiatry and Psychology Departments did not feel the rate or severity of self-injury was of an intensity that would lead them to challenge the guardian's position in court. Thus, this individual was not formally assessed by Psychiatry. The Reiss Screening of the entire population of individuals not receiving psychotropic medication effectively assessed for any changes in status that might have occurred in the months prior to the administration of the Reiss. All of those individuals prescribed psychotropic medication had been evaluated with a CPA, and all of the individuals admitted to the Facility in the last six months were prescribed psychotropic medication and, thus, were evaluated with a CPA. The Psychiatry Department indicated they plan to include an evaluation with the Reiss Screening instrument for any individual they are asked to perform an initial consult, as they have done in the past. Accordingly, the finding of substantial compliance was carried forward from the prior review. During the onsite review, a member of the Monitoring Team discussed with both the Director of Behavioral Services and the Director of Psychiatric Services the need to maintain an effective system for assessing individuals who undergo a change in status with the Reiss Screening Instrument as part of their overall psychiatric assessment/consultation process for these individuals.	
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 Behavioral Services. These interactions also were visible in the observation of the Psychiatric Clinic, 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 factors that might be affecting 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 process and time allocation of the Psychiatric Clinic on 10/2/12 was similar to those that had been observed during the Monitoring Team's previous onsite reviews. The observations of the Psychiatric Clinics and the related documents illustrated the	Noncompliance

#	Provision	Assessment of Status	Compliance
		active collaboration between the two disciplines of psychology and psychiatry. A prior 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 Structural and Functional Assessment 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. The Psychiatry Department, working in conjunction with the Psychology Department, had developed a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. The discussion with regard to Section 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 Psychiatric Clinics were nursing, psychiatry, psychology, direct support professionals, and the QDDP. Disciplines such as Speech Therapy, Occupational Therapy, and Physical Therapy were, of course, not able to attend the Psychiatric Clinics, due to additional constraints on their time allocation. 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 19 individuals in the sample. This review indicated that the Attending Psychiatrist attended a recent individual ISP Meeting for 11 of these individuals (58%). The specific records that contained this documentation were those of: Individual #127, Individual #232, Individual #33, Individual #27, Individual #25, Individual #318, Individual #7, Individual #82, Individual #146, Individual #299, and Individual #154. On 10/4/12, a member of the Monitoring Team attended the ISP meeting of Individual #140, 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 adequately reflected the psychiatric aspects of the individuals' treatment in none of the individual records reviewed (0%). Usually, the records contained a brief discussion of the psychological treatment plan and reference to the individuals' psychotropic medication. However, no information was included that reflected the specific 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. The newest format of the ISP that the Facility had just begun to use the week of the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team's onsite review included a separate subsection of the ISP to specifically discuss the psychiatric aspects of the individual's care, as well as the contribution of the Psychiatrist, if they were present. It was hoped that with this addition, teams would both discuss and document the psychiatric treatment plan in more detail. In addition, the revised risk rating form included a section on "Behavioral Health" that was intended to combine psychological and psychiatric information. 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 ISP meetings, this still had not been accomplished on a regular basis for the majority of individuals who were prescribed psychotropic medication. In addition, ISPs did not reflect adequate integration of psychiatric treatment plans.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	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 in portions of the documentation found in the sample of 19 records of individuals who were 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. The Monitoring Team's previous reports identified a deficiency in this process related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified in the Structural and Functional Assessment and the PBSP as being present on a learned/behavior 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 potentially being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the corresponding Psychology Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the Facility had effectively rectified this problem through combined assessment and case formulation. None of the records contained in this sample contained a contradictory reference to a behavior solely being present on a behavioral basis in the Psychology section of the record, and then referenced as a target behavior of medication in the Psychiatry Notes. Instead, there was a discussion of the derivation of the monitored behaviors in the psychiatric section of the record, which primarily linked	Noncompliance

#	Provision	Assessment of Status	Compliance
		specific behaviors to the symptoms or manifestation of the underlying psychiatric diagnosis. The Psychology sections of the record, such as the PBSP and the Structural and Functional Assessment Report utilized separate subsections to specifically discuss the effects of the individuals' psychiatric disorders on their behavior, and then differentiated this from those behaviors derived from environmental or operant factors. The differentiation of the maladaptive behaviors with which the individual presented was related directly to the concluding requirement in this provision, which addresses "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors that were (in reality) related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk the individual would be prescribed unnecessary psychotropic medication. In addition, the individual might not receive the behavioral supports appropriate to address the problem. Alternately, the appropriate identification and differentiation of these factors, as was found during this review, decreased (if not eliminated) the risk a psychotropic medication would be inappropriately utilized to suppress learned behavior. In a corollary manner, it also assisted in ensuring the least intrusive and most positive interventions were used to address the individual's challenging behaviors. The Psychiatry Department's prior creation of a document entitled "Psychiatric Consultation – Diagnostic and Treatment Analysis" also assisted with this process. 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 Formulation." Although LBSSLC had effectively rectified the aforementioned problems in the individual records, the Facility was found to be in noncompliance with this section of the Settlement Agreement, due to the insufficient discussion in the ISPs of the teams' deliberations with regard to whether the use of psychotropic 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. This information should specifically include a discussion of whether psychotropic medication represented the least intrusive and most positive intervention, and should also identify the role of behavioral and/or programmatic interventions also being utilized. As also indicated with regard to Section J.8, although the Psychiatrists had begun to attend the ISP meetings, their contributions were not identified in the ISP documentation, and their absence was still noted for the majority of the meetings. Thus, the Facility should focus on including these aspects of the individual's psychiatric treatment considerations into the ISP discussions, and	

#	Provision	Assessment of Status	Compliance
		documenting the deliberations on which such decisions are based.	
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. The initial Monitoring Team's 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 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 Formulation subsection of the CPA, and a relatively newly developed document entitled "Psychiatric Consultation – Diagnostic and Treatment Analysis," which contained a specific subsection on "Risk vs. Benefit." There also were extended discussions in the Psychiatry subsections of the PBSPs. This information, which was formulated by the Psychiatrist, working in conjunction with the Psychology Department and the members of the IDT that attended the Psychiatric Clinics discussed both the realized and potential side effects of the medication, and then weighed them against the realized and potential benefits of the medication. These reviews were completed for each individual medication that the individual was prescribed. For most individuals, the actual realized benefits could be documented, but for newly-prescribed medications, a rationale was provided regarding what benefits would be expected. This documentation could benefit from additional consideration of possible reasonable alternative approaches, and the Monitoring Team discussed this with the Psychiatry Team during the onsite review. The current review found an adequate discussion of the risk-versus-benefit analysis in all of the 19 individual records contained in the review sample (100%). The documentation included a discussion of both the potential and realized side effects of the medication, as well as 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, as well as the expected timelines for realizing those benefits. (There is further discussion of this process below with regard to Sections J.13 and J.14). A member of the Monitoring Team attended the 10/3/12 meeting of the HRC and also interviewed the HRC Officer. The reviews performed at the meeting, as well as those that were observed during the Monitoring Team's previous onsite reviews, were very detailed. There were instances in which the HRC rejected behavioral plans because of insufficient information.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on the Monitoring Team's observation, the Psychiatrist that attended the ISP meeting of Individual #140 engaged the team in a discussion of these issues. However, this discussion was minimal, and did not clearly identify the risks versus benefits of the medication, nor did the team set forth a specific plan for minimizing the risks of the medication based on the individual's progress with other alternative strategies, including programmatic and environmental modifications. In fact, Individual #140 was a good example of an individual for whom alternative strategies were having a significant impact. The Psychiatrist pointed out that the individual was receiving three psychotropic medications and was currently doing well, so it would be reasonable to consider a challenge of one of the medications. The Psychiatrist indicated there was insufficient evidence to prove that each of them was independently effective. However there was insufficient time to carry out this discussion during the meeting, and the team also needed further time to consider the subject. Thus the team, including the individual's mother, did not adequately discuss the risk benefit issues during the meeting. The team also did not set a specific timeframe for revisiting the subject and/or behavioral criteria to indicate when the team would meet again. In addition, the review of the ISP documentation for the sample of 16% of individuals prescribed psychotropic medication did not indicate that a discussion of these important issues (that was commensurate with the detailed information that routinely appeared in the individual's records) occurred in the context of the individual's annual ISP meeting. In addition, the risk-versus-benefit discussions that appeared in the individual records could benefit from an extended discussion of the potential risks-versus-benefits of other alternate forms of treatment that had been considered by the IDT. The Facility was found to be in noncompliance with this provision. The Settlement Agreement specifies that the Interdisciplinary Team should weigh the risk-versus-benefit considerations, and 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." At the time of the review, the documentation was not adequate to show that teams were engaging in this discussion and documenting the results.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. LBSSLC had maintained tabular data that illustrated the yearly reductions in the rates of polypharmacy, dating back to 2005. This data clearly illustrated a consistent, marked reduction in the rates of polypharmacy. The current version of this document illustrated continued progress in reducing the frequency of polypharmacy with psychotropic medication. The following summarizes	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	the past and current status: ▪ The number of individuals prescribed six or more psychotropic medications had been maintained at zero since 2008, and the number prescribed 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 admitted from the community within the last year. The number of individuals prescribed four psychotropic medications had decreased from 18 in 2005, to a range of three to seven since that time, with the current frequency of seven. The corresponding data for the individuals prescribed three psychotropic medications indicated a decline from 44 in 6/05, when monitoring began, to 15 in 2/11, and had been maintained at 18, as of 8/11 and 2/12. The 8/12 compilation indicated this number had now been reduced to 15. ▪ 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 10/12. ▪ 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 2/12 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 for the last four 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 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 2012 indicated that a thorough review of each of the 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 Psychiatry, Program Compliance Monitor for Psychiatry, and the Psychiatric Assistant. The Psychiatry Clerk also had begun to attend these meetings. On 10/3/12, a member of the Monitoring Team attended the Polypharmacy Committee Meeting. Team members indicated the format and content of this meeting were	

#	Provision	Assessment of Status	Compliance
		representative of prior meetings, and included a brief clinical review of each individual whose psychotropic medication regimen met the criteria of polypharmacy. The format of the meeting was also similar to that observed during the Monitoring Team's prior onsite reviews. The primary focus of these case-centered reviews related to the continued efforts to decrease the individual's medication, as well as determining 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, who, due to the acuity of their psychiatric and behavioral presentations, were deemed to require a more structured environmental setting. These individuals often were prescribed multiple psychotropic medications while in the community. 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 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. For example, an individual admitted to the Facility in February 2011 (after a number of failed community placements) had been prescribed six psychotropic medications at the time of admission. Since the individual's admission, these medications recently had been decreased to three, and the individual was being actively considered for community placement. During the Monitoring Team's previous review, the Facility reported the Psychiatry team believed the current medications were justified for a number of individuals, and without them, the individuals' psychiatric status would deteriorate significantly. The terminology contained in this provision clearly indicated medication regimens meeting the criteria of polypharmacy could be maintained if sufficient evidence was presented 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 begin to assemble the necessary historical empirical evidence to support these opinions. The Facility had responded to this recommendation by developing three subcategories of polypharmacy. These 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 admitted from the community on multiple psychotropic medications. At the 10/3/12 Polypharmacy Committee Meeting, the data presented was organized	

#	Provision	Assessment of Status	Compliance
		according to these 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 eight individuals of the total 122 individuals receiving psychotropic medications. However, it should be noted that four of these eight individuals were admitted in 2011 and had previously been on the New Admission list. ▪ Although the Facility had made progress in decreasing their psychotropic medications, four of these individuals still met the criteria for polypharmacy. An additional four individuals were listed within the category of "New Admissions" in the last year (3% of the 122 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 entitled "Clinical Justification." This section reviewed the historical and current clinical status of the 16 individuals (13% of the 122 individuals receiving psychotropic medications) that Facility staff 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 detailed, historical empirical data required to substantiate clinical efficacy was present for all but the following three individuals: Individual #140, Individual #232, and Individual #310. The data presented in the justification for the other 13 individuals included historical and current empirical data to justify the efficacy of the psychotropic medication. The histories contained medication-specific information. This made it possible to ascertain the degree of positive improvement that had been accomplished by comparing the current rates of behaviors related to the psychiatric disorder to those present in the months and years prior to the introduction of the medication. The contemporary LBSSLC records only routinely carried forward data from the prior year. Thus, it was only by researching the historical record that this valuable information could be identified. During the onsite review, the Director of Psychiatry indicated that the newly added Psychiatric Clerk, working in conjunction with the other members of the Psychiatry Department, had compiled the historical research to provide the data necessary to justify an individual's current psychotropic medication. This usually involved retrieving the individual's archival record, so that several years of historical information could be analyzed. In summary, at the time of the 10/2/12 Polypharmacy Committee Meeting, 28	

#	Provision	Assessment of Status	Compliance
		individuals (23% of 122) at LBSSLC met the criteria for polypharmacy. ▪ Eight of these 28 individuals (28%) had been placed in the "Active" category, which meant that the Psychiatry Team was still actively addressing the individual's medications. o Four of these individuals had been admitted to the Facility in 2011 on multiple psychotropic medications, and the Facility was still in the process of actively challenging their psychotropic medications to determine the lowest effective dosage and, in some cases, was still attempting to completely remove some medications. o Four individuals were long-term residents of the Facility who continued on multiple psychotropic medications that were, by definition, not entirely effective for their psychiatric disorders or they would not have been placed in the "Active" category by the Facility. This included: Individual #61, Individual #25, Individual #4, and Individual #33. These individuals had complex, difficult to treat psychiatric disorders and the Psychiatry Team was still actively adjusting their medications. ▪ There also were four individuals (14%) in the "Active – New Admissions" category, who had been admitted within the last several months. Thus, the Facility was still engaged in the process of challenging their medications, as noted above. ▪ The final category of "Stable" polypharmacy provided data on 16 individuals for whom the Facility had determined that their psychotropic medications could be justified (57%). The review of this material by a member of the Monitoring Team concluded that this information was sufficiently detailed to substantiate the efficacy of the medications for 13 individuals (81%). Those for whom this justification was not present was: Individual #140, Individual #232, and Individual #310. This appeared to mostly be due to a lack of information in the prior records. Thus, if one accounts for the eight individuals who were admitted to LBSSLC from the community on multiple psychotropic medications in 2011 and 2012, and the 13 individuals for whom the empirical evidence was sufficiently detailed to support the contention that their prescribed medications were necessary, there remained seven individuals (four from the Facility's Active category and three from their "Stable" category) of the total of 122 (six %) who were prescribed psychotropic medication and for whom current justification for their psychotropic medications could not be determined. These individuals were not noted to be experiencing any untoward side effects from these medications. With regard to the three individuals from the "Stable" category, there was no reason to believe that the medications were not effective, as the individuals were stable. The Psychiatry Team believed that the severity of the individuals' psychiatric disorder was such that it would present too much risk to the	

#	Provision	Assessment of Status	Compliance
		individual to challenge their existing medications, which would be the only way to prove efficacy, in light of the deficiency in the historical records. The four individuals in the "Active" category were not stable, and presented with complex psychiatric disorders, and the Facility was still actively working to adjust their medications to improve their quality of life. The Facility was found to be in substantial compliance with this provision, as they continued to actively assess the individual's need for continued polypharmacy on a monthly basis, as well as in the Psychiatric Clinics. In addition, the rate of polypharmacy that could not be justified with the empirical data had been reduced to six percent of the total of individuals who were prescribed psychotropic medication at LBSSLC as based on the calculations described above.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	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 Dyskinesia Identification System: Condensed User Scale (DISCUS), and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale (MOSES) 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 prescribing practitioner reviewed and signed the documentation. The Director of Psychiatry indicated that the nursing staff performed the MOSES evaluations, and the Psychiatry Assistant performed the DISCUS examinations. As noted in previous reports, the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all of the 19 individuals (100%). The records of the 19 individuals contained documentation that the prescribing practitioner had reviewed the MOSES evaluation in a timely manner (within 14 calendar days) for all of these individuals (100%). 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 indicated the DISCUS was current, and had been performed quarterly for the past year for all but one individual (date of most recent DISCUS evaluation): Individual #82 (most recent DISCUS was dated 6/6/12). Thus, the DISCUS had been performed as	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		specified for 18 of the 19 individuals (95%). The prescribing practitioner had signed all of the completed DISCUS evaluations in the sample records within 14 calendar days of completion (100%). The specific information for the individual for whom a problem was noted has 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. Although Reglan is prescribed for gastroesophageal reflux disease (GERD), it has pharmacological properties that are similar to those of antipsychotic agents. The Psychiatry Assistant also performed the DISCUS for those individuals prescribed 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 (23% of the 22 individuals fitting the above criteria) was selected: Individual #323, Individual #136, Individual #199, Individual #74, and Individual #176. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four of these individuals (80%). The missing documentation was for Individual #199, for whom no documentation of a MOSES evaluation could be found prior to the 7/9/12 evaluation. The only individual in this sample for whom the documentation had not been signed in a timely manner was Individual #176 (80%) for whom there was a gap from 1/3/12 to 1/20/12 before the prescriber's review was performed. 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%). The prescribing practitioner also had uniformly reviewed and signed these evaluations in a timely manner for all of these individuals in the sample (100%). The review of the overall completion rate of the MOSES every six months, as specified in the Settlement Agreement, indicated that these evaluations had been carried out as specified for 23 of the 24 individuals in the overall sample of 19 individuals receiving psychotropic medication and five prescribed Reglan (96%). The assessment of the timely review of these documents by the prescriber indicated that	

#	Provision	Assessment of Status	Compliance
		the review had been completed within 14 days for 23 of the 24 individuals (96%). A similar analysis of the assessments with the DISCUS every three months indicated that they had been performed as specified for 23 of the 24 individuals in the combined sample (96%). The corresponding analysis of the timely signature of these documents was 100%. These uniformly high rates of completion indicated the Facility had developed a system to routinely ensure side effect monitoring tools were completed, as specified in the Settlement Agreement. This resulted in the finding of substantial compliance for this provision.	
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 19 individuals (16% of those receiving psychotropic medication) indicated a description of the specific symptoms supporting the psychiatric diagnosis(es) of record could be identified for all of the individuals (100%). The Monitoring Team's previous review found that 90% of the records contained an adequate justification for the psychiatric diagnosis of record. The review prior to that found an 80% rate. At the time of the initial Monitoring Team's 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. During more recent reviews, 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." Issues related to the psychiatric diagnosis also are discussed with regard to Sections J.2 and J.6. 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 medication. A persistent problem with the documentation in the LBSSLC records had been 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. Collaboration between the Psychiatry and Psychology Departments had effectively	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		addressed these problems through systemic interventions and shared case collaboration, as described above with regard to Sections J.8 and J.9. These interventions essentially consisted of differentiating those behaviors that were present on a behavioral basis, from those that either represented symptoms of the psychiatric disorder or a direct manifestation of the disorder. These discussions were then carried out consistently throughout the different sections of the record, and could be identified in 100% of the sample of individual records reviewed. Of course, there were a number of individuals for whom it was determined that the behavior was derived from both psychiatric/biological factors and behavioral/environmental contingencies. In these situations the relevant documentation described the mechanism that accounted for this dual derivation. This usually related to individuals who had a biological condition such as a Bipolar Disorder that could be exacerbated by environmental factors, or an individual whose primary problem derived from a Pervasive Developmental Disorder that would decrease their ability to effectively deal with environmental stressors and thus lower their threshold for a physiologically mediated maladaptive response. The question of the efficacy of the prescribed psychotropic medication is also referred to in this provision. What the Settlement Agreement requires is that: "the treatment plan for the psychotropic medication identifies… 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." The following summarizes the Monitoring Team's findings with regard to the Facility's efforts in this regard: ▪ In 16 of the 19 records reviewed (84%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. The records of three Individuals for whom this documentation could not be identified were those of: Individual #27, Individual #25, and Individual #34. This was an important finding because it showed that for many individuals, efficacy already had been established. However, for the remaining individuals, the Settlement Agreement required the Facility to implement a process to measure the efficacy of the medications. ▪ In reviewing the Quarterly Review forms, for the 19 individuals in the sample (100%), they carried forward six months of behavioral data. It was presented in tabular form and the psychological sections of the record presented the corresponding data in both tabular and graph format. The juxtaposition of Quarterly Reviews that were six months apart allowed one to visually ascertain the trends in the data over a two-year period of time. ▪ For 19 individuals in the sample (100%), the behavioral data that was monitored was specific to the individual and included the overt behavioral	

#	Provision	Assessment of Status	Compliance
		manifestations of the psychiatric disorder, and where relevant, the specific symptoms of that disorder. ▪ The mechanism by which the overt behavior was derived from the psychiatric disorder was reviewed with a narrative description in the Bio-psycho-Social-Spiritual Formulation section of the CPA, and then in more specific detail in the "Psychiatric Consultation-Diagnostic and Treatment Analysis." The Facility had standardized this process so that the material was present in 100% of the individual records reviewed. ▪ The Behavioral Data was actually collected and maintained by members of the Psychology staff and first appeared in the BSP, and then was transferred to the Quarterly Review documents. However the discussions regarding which behaviors were derived from the Psychiatric disorder occurred in the context of the Psychiatric clinics, as well as informal discussions between the psychology and psychiatry staff. ▪ The behavioral data section of the Quarterly Psychiatric Reviews included a discussion of the timelines for when positive effects of newly prescribed medication could reasonably be expected to occur, and also indicated if that time had passed due to the length of administration. This was primarily accomplished with a specific column in the section listing the current medications entitled "Dosage Change/Date." It was in this section that the addition of a new medication or the change in the dosage of an existing medication was documented and then elaborated on in the narrative section of the document. It should also be noted that the addition of a new medication or a change in the dosage of an existing medication would automatically trigger a follow-up review in one month. At the monthly review, the effects of the change would be monitored and discussed. These reviews were performed in addition to the Quarterly reviews and did not replace a quarterly review. Thus an individual whose medication was actively being titrated would be followed on a monthly basis in between the scheduled quarterly reviews. This information was also routinely incorporated into the Quarterly Review document format so that it was uniformly present in 100% of the records reviewed. LBSSSLC 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 could be greatly enhanced by the inclusion of 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 required would vary according to the individual, but could extend back for several years. The Psychiatry Department had compiled this data for the individuals in their "Stable" polypharmacy group to justify the necessity of the medications prescribed for these individuals. The Facility would benefit from the	

#	Provision	Assessment of Status	Compliance
		inclusion of this information in the individual records, as discussed with regard to Section J.11. The final section of this provision relates to the frequency and adequacy with which the Psychiatrist reviewed individuals receiving psychotropic medication. The review of a sample of the records indicated that quarterly reviews were performed as specified in this provision for 18 of the 19 individuals reviewed (95%). The only individual whose records did not contain the necessary information was that of Individual #318, for whom the most recent quarterly review that could be found in the record was dated 4/26/12. However, there was documentation in the record showing the Attending Psychiatrist had seen this individual during a psychiatric consultation on 8/2/12, and the Consulting Psychiatrist had seen her on 8/17/12, as part of the process of updating the CPA. Documentation was present to show the individuals had been directly observed in conjunction with the quarterly reviews for the entire sample of 19 individuals (100%). The format for the Quarterly meetings in general followed the format of the corresponding form used to document the meting and the relevant data. In addition to the behavioral and pharmacological data discussed above this material included basic information, such as the individual's weight, and vital signs. The laboratory data included the most significant metabolic and hematological lab values, as well as the results of the most recent electrocardiogram (EKG). If the individual was receiving a medication, such as a mood stabilizer requiring periodic monitoring of blood levels, these were also reported. The results of the most recent Moses/Discus evaluations were reported, as well as any significant medical changes or events including the individual's seizure status, if applicable, and whether the individual recently had seen the Neurologist. All of this information was available on the quarterly review documentation for the team members to review and was discussed according to its relevance to the individual's current status. Based on observations, the psychology staff reviewed the behavioral data with input from the direct support professionals who worked with the individual on a daily basis. Nursing staff reviewed the relevant medical and laboratory data. The Psychiatrist chaired the meting, provided insights on the current issues, and guided the discussion as to whether any medication or programmatic changes might be beneficial. The QDDP also was always present and was an active participant in the meeting. On 10/2/12, a member of the Monitoring Team observed the Psychiatric Quarterly review meetings. 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 in their residence. The duration of the individual reviews ranged from 30 to 45 minutes, with ample time for team discussion, as well as interaction with the individual. The	

#	Provision	Assessment of Status	Compliance
		composition of the meeting attendees is discussed above with regard to Section J.8. It is also important to note that the quarterly Psychiatric Clinics were not the only formats in which the individual's status was discussed, or the individual was seen. In addition, an individual would be seen one month after the initiation of a new medication or a change in the dosage of an existing medication. The individual also would be reviewed monthly or more frequently if they were not considered to be stable and it was felt that more active psychiatric involvement would be beneficial. The Psychiatrist was available for telephone consultations throughout the week, and these could result in the initiation of a modified review meeting that would be held on the unit as soon as possible, and usually within hours. These meetings were documented in either Psychiatric Consultation note or a dictated Integrated Progress Note as described below. In reviewing records, the various types of ongoing assessment and monitoring had occurred for all of the 19 individuals (100%) in the sample as dictated by their specific psychiatric needs. A listing of the various documents produced for these various encounters were as follows: ▪ **Revised Comprehensive Psychiatric Evaluation -** Revised annually and the individual is interviewed/observed as part of this process. The Psychiatrist also interviewed members of the IDT while preparing the documents; ▪ **Quarterly Psychiatric Clinic -** Quarterly Reviews as described above; ▪ **Psychiatric Consultation -** These occurred on an as-needed basis to address a change in the individual's status and were documented by a separate note entitled "Psychiatric Consultation;" ▪ **Dictated Integrated Progress Note -** These were completed for encounters that occurred on an as-needed basis, and essentially represented briefer notes for less significant situations than those that would have precipitated a psychiatric consultation. The individual was usually seen, but might not have been, depending on the rationale (i.e., a note commenting on an elevated blood level and the response would not have involved seeing the individual); ▪ **Psychiatric Consultation – Diagnostic And Treatment Analysis -** Annually, in conjunction with the ISP. The individual is usually not seen. This is a summary document that covers the following topics: o Medications with rationale; o Diagnoses/symptoms/target symptoms; o Derivation; o Risk of illness; o Benefit of pharmacological therapy (including past history); and o Future plans 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	

#	Provision	Assessment of Status	Compliance
		to the completion of the CPAs, the Quarterly Review documentation, and the "Psychiatric Consultation – Diagnostic and Treatment Analysis" for those individuals prescribed psychotropic medication. This documentation effectively addressed the important point of substantiating the clinical rationale for the psychiatric diagnosis. The collaboration between Psychiatry and Psychology had also rectified the problem of the dual classification of behaviors described in the Monitoring Team's previous reports (as discussed with regard to Sections J.8 and J.9). Thus, LBSSSLC had fulfilled the requirements set forth in this provision, many of which are also addressed in other sections of the Settlement Agreement. Therefore, the Facility was found to be in substantial compliance with this provision.	
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 19 individuals receiving psychotropic medication indicated that 16 individuals (84%) had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning the 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 were present in the individual records for all of these individuals (100%). The Facility's process for obtaining consent for a new psychotropic medication began in the context of the Psychiatric Clinic. At these meetings, the Psychiatrist, working in conjunction with the members of the IDT that routinely attend these meetings formulated the recommendation for a medication change. During the meeting, an attempt was made to reach the guardian by telephone. The Psychiatry Department estimated that the team was successful in reaching the guardian in this manner approximately 30% to 40% of the time, but no precise records were maintained. If the initial call was not successful, the QDDP or the Psychologist would usually secure verbal consent after the meeting. For those individuals who relied on the Facility Director for consent, the initial process was accomplished through written documentation. The annual consent process was accomplished by mailing documents to the guardian. A recent sample of the documents that were sent to the guardian as part of this process was requested. The Monitoring Team's review of these documents indicated this information included the Informed Consent form, which contained separate sub-sections for each of the following items: ▪ Legal status; ▪ Treatment/procedure and purpose; ▪ Justification for plans of treatment; ▪ Psychoactive medication (this section contained psychiatric diagnosis and rationale for the medication); and	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Risk-versus-benefit analysis. The above documentation was accompanied by a copy of the most recent PBSP, which also contained a section related to the psychiatric medication and corresponding risk-versus-benefit considerations. The Psychiatry Department, working in conjunction with the Psychology Department and the Human Rights Officer was in the initial stages of developing a process to effectively remove the Psychology Department from the primary responsibility of obtaining the consents for psychotropic medications. The Psychiatry Department had developed a document entitled: "Psychiatric Medication Treatment Plan." As the responsibility for securing the consent is transferred from the Psychology Department to the Psychiatry Department, this document will augment the existing forms of documentation described in Section J.13 and will become a primary document in the informed consent process. As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit analysis contained in the Psychiatry section of the record demonstrated considerable improvement, as compared to the results of prior reviews. However, this material had not yet been incorporated into the ISP discussions and related documentation, and was only in the initial stages of implanting that process. These deliberations must also occur and be documented during the ISP process so as to incorporate the observations and opinions of the entire treatment that participates. In addition, the Facility was implementing a major change in the consent process as the responsibility for this process had been transferred from the Department of Behavioral Services to the Psychiatry Department. . Accordingly, for these reasons, the Facility remained out of compliance with this provision. As they implement their new procedure to move the primary responsibility for obtaining the consents from the Psychology Department over to the Psychiatry Department, the more in-depth risk-versus-benefit analysis will be a part of the process. It will, obviously, take some time to put this process into full operation, but the Facility already made progress as evidenced by the recently developed document entitled "Psychiatric Medication Treatment Plan."	
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,	Based on the Monitoring Team's observation of the Neurology Clinic on 10/3/12, the Neurologist, the Director of Psychiatry, the Medical Director, the individuals' Primary Care Provider (PCP), the Clinical Pharmacist, and other members of the professional team, all attended the Neurology Clinic. This was also consistent with observations made during the Monitoring Team's previous reviews. A member of the Living Unit nursing staff accompanied the individual to the Clinic, and an additional nurse assigned to the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Clinic helped to coordinate the flow of the individual 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 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 six individuals within the sample of 19 individuals who required and received neurological consultation within the last six months. The review of records indicated that during this time period, the Neurologist reviewed the following individuals: Individual #193, Individual #68, Individual #232, Individual #25, Individual #318, and Individual #146. The Neurology Consultation Note documented the attendance of the Psychiatrist in all of these records. The attendance of the Psychiatrist at the Neurology Clinics of the individuals who received psychotropic medication also had been verified in each of the Monitoring Team's previous reports. 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 individual's annual medical summaries. These summaries were not purged, and contained valuable longitudinal information, which extended back for several years in some cases. In summary, the collaboration between Neurology and Psychiatry was 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 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 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 existed. His impression was that, based on this feedback, there had been adequate time, but that	

#	Provision	Assessment of Status	Compliance
		if circumstances were to change in the future, it would be relatively easy to add additional neurological consultation time. Currently, one consulting neurologist provided neurological consultation two afternoons per month, and a second consultant provided an additional afternoon per month. The second consultant had recently terminated his consulting role at LBSSLC, but had been replaced by another consultant, who is the Chief of the Neurology Department at the Texas Tech Health Center. The contract to provide neurological services at LBSSLC is with the Texas Tech Health Center and is not a direct contract with the Neurologists. The first consultant's primary focus was on the treatment of individuals with seizure disorders, while the newest consultant's 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 newest consultant also presented an hour-long Continuing Medical Education Program at the beginning of each Clinic. 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 adequate 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. In those situations where the direct support professionals do not provide an adequate description of the events that preceded the chemical restraint, the Facility should ensure that the necessary information is collected and appears in the face-to-face debriefing and/or the Psychiatry Department's post-incident review. (Section J.3)
3. The initiative to implement Desensitization Plans and/or other strategies to reduce the need for pre-treatment sedation should be accelerated. (Section J.4)
4. The initiative to make it possible for the individuals' Attending Psychiatrist to attend their annual ISP Meeting should be supported. (Section J.8)
5. The Facility should expand the information that is included in the ISP regarding the individual's psychiatric status. This should also include a brief description of the Psychiatrist's contribution to the process where appropriate. (Sections J.8 and J.9)
6. The risk-versus-benefit discussions also should include a discussion of the other treatments the team had considered and/or were utilizing. (Section J.10)
7. The Facility should fully integrate the progress 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, as well as the ISP

documentation. (Sections J.10, and J.14)

8. An interdisciplinary review should be conducted of the Human Rights/Consent process with regard to the guardian 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)
9. The current initiative to transfer the responsibility for the consent process for psychotropic medications from the Behavioral Services Department to the Psychiatry Department should be further developed. (Section J.14)
10. The Facility should evaluate quality, as well as the presence or absence of an item, when performing the internal QA reviews. (Facility Self-Assessment)
11. The Facility should more fully incorporate the results of their internal QA record reviews into their self-assessment process for more sections of the Settlement Agreement then is currently done. (Facility Self-Assessment)

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

1. Potential mechanisms to retain the longitudinal, historical behavioral data that had been identified to facilitate determination of the efficacy of psychotropic medication(s), which had been started multiple years ago, should be developed so that this valuable information can be included in the individual records. (Sections J.11 and Section J.13)
2. Going forward, the Facility should maintain a system for the psychiatric evaluation for those individuals that undergo a change in their mental/behavioral status that includes the administration of the Reiss Screening Instrument as part of the Psychiatric consultation process. (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: ▪ **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 for the past three months, as provided, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201; o For Section K.4, Crisis Intervention Restraint Plans and Monthly PBSP Progress Notes for the past three months, as provided, for: Individual #27, Individual #61, and Individual #124; o For Section K.5, Structural and Functional Assessment Report (SFAR) and/or Structural and Functional Assessment Review/Update, as provided, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201; o For Section K.5, Psychological Evaluations for: Individual #251, Individual #135, Individual #276, Individual #79, and Individual #280; o For Section K.5 and K.6, Psychological Assessments, including the Inventory for Client and Agency Planning (ICAP) Evaluations, as available for: Individual #185, Individual #73, Individual #61, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #276, Individual #7, Individual #135, Individual #315, Individual #79, Individual #201, Individual #30, and Individual #280; o For Section K.7, Psychological Assessment Admission Summaries or 30-day Psychological Summary for: Individual #30, Individual #27, and Individual #40; o For Section K.8, Counseling treatment plans, monthly progress notes, and session notes, as available for: Individual #34, Individual #121, and Individual #125; o For Section K.9, Positive Behavior Support Plans, as available for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201; and o For Section K.10, Monthly PBSP Progress Notes for the past three months, as provided, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201. ▪ **Interviews and Meetings with the following**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 10/1/12; o Tracey Snow Murphy, Director of Residential Services, and Paul Thomas, Director of

	Active Treatment/Recreation, on 10/2/12 and 10/3/12; o Paul Thomas, Director of Active Treatment/Recreation; Rodshadi Moore, Active Treatment Supervisor; Adrian Richardson, Active Treatment Coordinator; Robbie Walker, Active Treatment Coordinator; and Erika Flores, Active Treatment Coordinator, on 10/2/12; o Tracey Snow Murphy, Director of Residential Services; Paul Thomas, Director of Active Treatment/Recreation; Christiana De Los Santos, Qualified Developmental Disabilities Professional Educator; Marc Lopez, ISP Technician; Sandra Kennedy, QDDP Coordinator; Jim Forbes, Director of Behavioral Services; and Carolyn Milton, Assistant Director of Behavioral Services, on 10/3/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and George Zukotynski, State Office Coordinator for Psychology/Behavioral Services, on 10/3/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; George Zukotynski, State Office Coordinator for Psychology/Behavioral Services; Bob Robbins, QA Program Compliance Monitor; Tracey Snow Murphy, Director of Residential Services, Marilyn Foster, QA Program Compliance Monitor, and Dawn Ripley, Director of Quality Assurance, on 10/3/12; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 10/4/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and Texas Tech faculty and students, on 10/4/12; o Tracey Snow Murphy, Director of Residential Services, on 10/4/12; and o Mary Ortiz, Director of Competency Training and Development, on 10/5/12. ▪ **Observations Conducted**: o Psychiatric Clinic, on 10/2/12; o Staff training at Violet (523), on 10/2/12; o Staff training at Willow (520), on 10/3/12; o Behavior Support Committee Peer Review Meeting, on 10/4/12; o Observation of SAP Integrity Check at Birch (514), on 10/4/12; 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: ▪ Aspen (513), on 10/1/12; ▪ Birch (514), on 10/1/12 and 10/4/12; ▪ Elm (515), on 10/1/12; ▪ Willow (520), on 10/2/12; ▪ Gym (512), on 10/2/12; ▪ Oak (518), on 10/2/12; ▪ Maple (517), on 10/2/12; ▪ Fir (516), on 10/2/12; ▪ Zinnia (528), on 10/3/12;

	▪ Iris (527), on 10/3/12 and 10/4/12; ▪ Violet (523), on 10/3/12; ▪ Tulip (526), on 10/3/12 and 10/4/12; ▪ Pine (519), on 10/5/12; ▪ Lily (524), on 10/5/12; ▪ Education and Training Center (511), on 10/5/12; and ▪ Aspen (513), on 10/5/12;
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section K, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Section K-Psychology Settlement Agreement Cross References with ICF-MR standard (Revised December 2010). Discussions during the onsite visit reflected efforts by the Facility to modify the previous self-assessment methodology by targeting data based on processes currently in place (e.g., behavioral services tracking grid data). The direction of these efforts appeared productive and promising. Final self-assessment methodology, however, was still yet unclear, because the process of determining additional variables and related methodology was not yet fully completed. Based on the verbal reports, it appeared that ongoing changes related to the monitoring tool were highly likely. ▪ Used other relevant data sources and/or key indicators/outcome measures. o The current self-assessment contained many informal review formats, including behavioral services tracking grids (e.g., excel spreadsheets for PBSPs, psychological assessments, psychological evaluations, structural and functional assessments, monthly PBSP progress notes, IOA and integrity/checklists, etc.), BSC attendance rosters and meeting minutes, revised assessment and intervention formats, as well as record and permanent product reviews. ▪ The Facility consistently presented findings based on specific, measurable indicators. ▪ The Facility consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section K.2. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Progress continued with regard to psychologists pursuing BCBA credentialing. Two psychologists had completed all coursework as well as supervision requirements, three psychologists had completed all of the required coursework, and four psychologists were currently enrolled in coursework. These seven psychologists also were receiving necessary supervision.

	Consistent progress was evident in the current internal peer review system. However, similar progress in a sustained external peer review system was not as conspicuous. Improvement continued in the implementation of monthly PBSP progress notes, including the use of effective graphing conventions. However, concerns remained regarding their timely completion. In addition, it was not evident that these progress notes were utilized to facilitate data-based decision making, particularly with regard to revising behavioral programming. Progress was noted with regard to the completion of comprehensive psychological evaluations, including formalized standardized testing, as well as in the timely completion of psychological assessment updates. However, the majority of individuals continue to have outdated standardized tests of intelligence and adaptive behavior. Since the Monitoring Team's previous visit, improvement in the development of quality functional assessments and counseling supports was also evident. In addition to addressing remaining areas of concern, these improvements will need to be available to all individuals served by the Facility, as appropriate. Continued improvement in the quality of PBSPs was observed, and work continued to make the additional improvements necessary. In addition, progress was evident in the completion of IOA probes as well as competency/integrity checks. In addition, issues surrounding the adequacy of training, including competency based training for part-time or pulled staff, as well as the development of systems to comprehensively monitor these trainings remained a concern.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Since the Monitoring Team's last visit, progress continued to be observed within the Department of Behavioral Services by psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing. At the time of the current visit, two staff within the Department had obtained their BCBAs. That is, of the current 11 psychologists (including the Director and Assistant Director, only two (18%) were currently BCBAs. This finding was consistent with reports provided during the Monitoring Team's previous visit. Based on current verbal reports, the Director and, more recently, the Assistant Director did not carry caseloads. Consequently, although BCBAs reviewed PBSPs, none of the psychologists currently writing PBSPs had a BCBA. According to documentation provided in the Section K action plan, at the time of the current onsite visit, two psychologists had completed all coursework as well as supervision requirements and were preparing to re-take the exam. In addition, three psychologists had completed all of the required coursework, and the remaining four psychologists were all currently enrolled in the University of North Texas behavior analyst course sequence. This included three psychologists who recently had initiated	Noncompliance

#	Provision	Assessment of Status	Compliance
		coursework this Fall 2012 semester. In addition, according to summary documentation in the Section K action plan, seven psychologists were currently receiving necessary supervision. In summary, at the time of the Monitoring Team's current visit, it appeared that all psychologists were making progress toward certification. The Facility was rated as being in noncompliance with this provision, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	As previously reported, Jim Forbes, M.Ed., BCBA, Director of Behavioral Services, held a Master's degree in School Psychology, and received his BCBA in March 2009 (recently renewed in March 2012). He had been employed in his current position for over ten years, and had extensive experience supporting individuals with intellectual, mental, and physical disabilities. In conjunction with the current State Office Coordinator for Psychology/Behavioral Services, and as reported in a number of the Monitoring Team's previous reports, 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. No significant change in the administrative structure of the Behavioral Services Department was reported since the Monitoring Team's last visit. The only change had been that the Assistant Director recently was released from carrying a caseload. Current verbal reports indicated an effort to provide more individualized support from the Director and Assistant Director of Behavioral Services to individual psychologists. Based on the continued existence of a qualified Director of Behavioral Services, the Facility remained in substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Progress continued to be evident in the current peer-based systems implemented to provide internal peer review of psychological services. However, progress in the area of external peer review appeared to have diminished since the Monitoring Team's last visit. As noted in previous reports, LBSSLC had an internal peer review system that occurred through the Behavior Support Peer Review Committee Meetings (BSC). This meeting was designed for professionals from a diversity of disciplines and departments to attend, including Psychologists, Psychology Assistants, medical representatives (RN or MD), a Psychiatrist, a QDDP, a Speech Language Pathologist (SLP), a human rights officer (HRO), quality assurance staff (QA), and BCBAs.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in the Monitoring Team's previous report, the BSC met at least once during 17 (77%) of the 22 weeks between 10/14/11 through 3/9/12. In total, there were 19 meetings held during these 17 weeks. Overall, these meetings were well attended by the Director and/or Assistant Director of Behavioral Services, given that one or both were in attendance at 100% of the meetings. In general, it appeared that one or more psychologists, one or more psychological assistants, a QA/QI staff, and one or more speech language professionals were in attendance in approximately 100%, 94%, 82%, and 82% of BSC meetings, respectively. The Human Rights Officer was in attendance in 47% of meetings. Attendance by medical staff, including psychiatry or nursing, was not evident in any of the provided documentation. At that time, it appeared that a majority of psychologists attended at least one BSC meeting per month during December 2011, and January, February, and March 2012. BSC meeting minutes the Facility provided that had been completed since the Monitoring Team's last visit were reviewed. This included a sample of minutes from BSC meetings across a 22-week period from 3/30/12 through 8/12/12. Based on this review, it appeared that the BSC met at least once a week during 20 (91%) of the 22 weeks. In total, there were 23 meetings held during these 22 weeks. Overall, these meetings were attended by the Director or Assistant Director of Behavioral Services for 22 (100%) of the meetings. In addition, it appeared that one or more psychologists, one or more psychological assistants, a QA/QI staff, and one or more speech language professionals (SLPs) were in attendance in approximately 100%, 50%, 90%, and 90% of BSC meetings, respectively. These data reflected improvement in attendance since the Monitoring Team's last visit by QA/QI and SLPs professionals, but a significant decline by psychology assistants. The Human Rights Officer and medical staff (psychiatrist, physician, or nurse) were in attendance in 23% and 5% of meetings, respectively. Since the Monitoring Team's last visit, this reflected a decline in attendance by the HRO and a very slight improvement by medical staff. It appeared that a majority of psychologists (five or more) attended 16 (73%) of the BSC meetings. Overall, adherence to the weekly BSC schedule as well as supervision by the Director or Assistant Director of Behavioral Services at those meetings remained satisfactory. In addition, attendance by QA/QI and SLP staff also remained high, and improvement in attendance by psychologists was noted. However, participation by the HRO and medical staff remained low, and attendance by psychology assistants was observed in only half of the scheduled meetings. According to current Positive Behavior Support Practices policy, professionals with "knowledge and experience in… psychotropic medication (Doctor of Pharmacy RN)" are expected members of the Behavior Support/Peer Review Committee. In addition, when they were at the meeting, only one or two psychology assistants were typically in attendance. Under current policies, psychology assistants are not required to attend. However, their attendance, when possible, appears to be encouraged. According to	

#	Provision	Assessment of Status	Compliance
		Section K.3 of the Facility's Self-Assessment, attendance of psychological assistants was temporarily reduced in order to support vacant positions. It should be noted that, since the Monitoring Team's last visit, monthly Behavior Services Meetings were held for psychologists in April and May and for Psychological Assistants in May and June. Summary documentation as well as verbal reports indicated that in July 2012, individual or small group meetings between the Director of Behavioral Services and psychologists and psychology assistants were initiated targeting review and instruction of monthly PBSP progress notes. Individual meetings with the Assistant Director of Behavioral Services targeting workload issues were reported to have started in March 2012. During Monitoring Team's previous reviews it was noted that the internal peer review process was supplemented by the utilization of occasional external peer reviewers. Faculty and students from Texas Tech University initially provided onsite and offsite consultation, peer review, and in-depth case review. These reviewers were a Doctoral-level Board Certified Behavior Analyst (BCBA-D), as well as graduate students studying Special Education and Applied Behavior Analysis. Over time, external peer reviewers also had included the participation of psychologists, including BCBAs, from other Texas State SSLCs via phone conference. As reported in the Monitoring Team's previous report, it appeared that external peer reviewers, from either Texas Tech or Austin SSLC, participated in eight (50%) of the BSC meetings between 10/14/11 through 3/9/12. Currently, based on BSC meeting minutes between 3/30/12 and 8/12/12, it appeared that external peer reviewers from Texas Tech and/or Austin SSLC participated in three (15%) of the BSC meetings. These included meetings held on 4/20/12, 5/4/12, and 5/18/12. It should be noted that meeting minutes from a more recent BSC meeting was provided following the onsite visit. This documentation indicated that an additional external peer review meeting was held on 9/14/12. This meant that for the months of June through August monthly external peer reviewers did not participate in BSC meetings. In addition, it should be noted that the 5/4/12 meeting included a non-BCBA external reviewer, which did not meet the Monitoring Teams' stated criteria for BCBA participation in the external review process. In addition to meeting minutes, additional documentation reflecting other external peer review activities also was provided. This included a comprehensive case review of Individual #68, dated 4/25/12. The remaining documentation of external peer review activities, however, was somewhat unclear. That is, an email, dated 7/29/12, provided as evidence of an external peer review that was completed on 7/13/12 was inconsistent with the BSC meeting minutes from 7/13/12. More specifically, the meeting minutes, dated 7/13/12, did not evidence the participation of any external reviewers. A similar	

#	Provision	Assessment of Status	Compliance
		inconsistency was noted for Individual #271, where documentation provided as evidence of external peer review, dated 6/15/12, as listed on the "Log of External Peer Reviews" did not correspond to meeting minutes for 6/15/12. In addition, "external peer review notes," dated 8/17/12, provided for Individual #4 did not reflect the nature of the external review or who completed the review. The above inconsistencies across documentation as well as lack of adequate supportive documentation (e.g., meeting minutes) could not be adequately resolved by the Monitoring Team. In its response to the Monitoring Team's draft report, the State indicated that these external peer review activities were conducted independent of the BSC process. Based on the State's request for further delineation of the standards used to assess various components of the Settlement Agreement, the Monitoring Teams will be further defining criteria related to external reviews. However, in response to the State's comments related to this report, the Monitoring Team re-reviewed the documentation related to LBSSLC's external review process, and continued to find it inadequate to support: 1) adequate or documented attendance by Facility Behavioral Services staff at external peer review activities; 2) clear findings from the external peer reviews; and 3) documentation of response to the external peer review process. Although conducting external peer review separate from the BSC process might be acceptable, without the structured minutes that such a forum provides, the Facility will need to ensure adequate documentation is maintained and provided to document the implementation sufficient external peer review. Similar to descriptions in the Monitoring Team's past reports, the Monitoring Team's direct observation of the BSC continued to reflect diverse attendance and active participation by committee members, presentation of assessments and plans by their authors, and data-based review and decision making. Overall, critical peer review continued to be observed in a supportive atmosphere of learning and collegiality. As noted in the Monitoring Team's previous report, annual review of PBSPs and Safety Plans for Crisis Intervention (SPCIs) had been inadequate. More specifically, review of the Behavioral Services tracking grid at that time indicated that recorded BSC approval and/or expiration date had exceeded 12 months for 11% of individuals with PBSPs, and the BSC and HRC approval dates had exceeded 12 months for 20% of individuals with SPCIs. Review of the Behavioral Services tracking grid currently was completed to estimate the adequacy of annual review of PBSPs. Review of additional summary documentation evidenced that six (100%) of the six Crisis Intervention Restraint Plans currently implemented within the Facility were similarly approved by BSC and HRC. However, of the Restraint Plans listed, it appeared that only five (83%) of the six plans received consent within 30 days of plan development (i.e., the exception was Individual #288). In addition, based on provided documentation, it was unclear if parent/guardian	

#	Provision	Assessment of Status	Compliance
		consent had been ultimately obtained for Individual #288 and Individual #57, because documentation only noted that consents were "sent 8/2/12" and "sent 8/23/12," respectively. As subsequently presented with regard to Section K.9, review of the most current tracking grid, indicated that the recorded BSC approval expiration date were within 12 months for 110 (81%) of 136 individuals with PBSPs. The Monitoring Team's independent finding was similar to results reported in Section K.3 of the Facility Self-Assessment that stated that 23 (17%) of active PBSPs exceeded the one-year review period. In addition, HRC approval expiration dates were within 12 months for 107 (79%) of individuals with PBSPs. Lastly, the consent expiration date was within the 12 months for all (100%) of individuals with PBSPs. Overall, since the Monitoring Team's last visit, the continued improvements in internal peer review were not similarly reflected through sustained involvement of external peer reviewers in BSC meetings, and adequate documentation was not presented to show staff's involvement in other peer review related activities, the results of the reviews, and/or response to resulting recommendations. Because the external review system did not appear to maintain past progress, the Facility was not found in compliance with this component of the Settlement Agreement.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Progress had continued in the area of standardized data collection and data review. As described in the Monitoring Team's previous report, significant efforts had been made in the past to enhance and promote the effective use of a Facility-wide standardized data system. This system was developed to allow direct support professionals the ability to carry index cards, and when appropriate, immediately record data on the target and replacement behaviors of each individual with a PBSP as well as other relevant data. These efforts had been supported through collaboration with Texas Tech faculty and graduate students and behavioral services staff. Previous direct observations by one of the members of the Monitoring Team during informal site visits estimated that the data cards were immediately available for use (i.e., carried by the staff) in approximately 75% of the residential programs visited. This finding was noted across the Monitoring Team's last two visits. Currently, according to the Director of Behavioral Services, some "drift" was observed in the use of the cards, because the support from Texas Tech was less evident over the summer months. More specifically, in September 2012, Texas Tech students and faculty examined how well data collection procedures had maintained since April 2012. The findings of this examination indicated that: "the new data collection system appears to have maintained at a fairly consistent level, with only a small drift." Data reflected that 60% of homes were maintaining a 75% or greater compliance rate. Because this external review was recently completed, the use of the data cards was not systematically examined during the Monitoring Team's current onsite visit.	Noncompliance

#	Provision	Assessment of Status	Compliance
		To examine the nature of data collection, including standard procedures and methods typically utilized to summarize, monitor, and review progress, a sample of 14 individuals who had an ISP meeting within the last six months and who also had PBSP were selected and reviewed. Based on the Behavioral Services tracking grid, dated 10/4/12, this sample reflected 10% of total number (N=136) of active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from last three months, as available. Review of sampled documentation indicated that all 14 (100%) individuals had Monthly PBSP Progress Notes completed across the last three consecutive months (June, July and August). At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 14 (100%) of the individuals sampled. However, target and replacement (alternative) behaviors were consistent across the PBSP and monthly PBSP progress notes for only seven (50%) of the individuals sampled. More specifically, inconsistencies were found between the PBSP and monthly PBSP progress notes in either the target or replacement behaviors as defined in the PBSP and graphed on the progress note. This included Individual #73, Individual #279, Individual #251, Individual #125, Individual #61, Individual #7, and individual #201. It should be noted that a few of the inconsistencies might be based on review of PBSP that was recently updated (e.g., 10/8/12 for Individual #251, and 10/1/12 for Individual #125). Overall, the clinical notes appeared to be descriptive and offered clinical insight on the progress notes for 11 (79%) of the individuals reviewed. The exceptions were monthly notes that did not appear to offer any clinical insight beyond the graphed data. These included the PBSP progress note for Individual #185 (August to June 2012), Individual #73 (June and August 2012), and Individual 201 (August 2012). Monthly PBSP progress notes appeared to be completed in a timely manner for eight (57%) of the individuals sampled. More specifically, many of the monthly notes appeared to be completed over four weeks after the particular month the progress note covered. Indeed, in several cases, the delay in completion appeared to be approximately two or three months (i.e., Individual #73 and Individual #30) or the completion date was unknown due to lack of a signature or completion date (i.e., June and July note for Individual #251, and August note for Individual #276). Overall, it was noted that a switch from weekly progress notes to monthly progress notes occurred for all of the individuals sampled in June, July, or August. Lastly, operational definitions of target and replacement behaviors were added to the monthly notes for all of the individuals sampled in June, July, or August. It could not be determined based on the review of sampled monthly progress notes whether or not PBSPs were revised due to current behavioral functioning. That is, descriptions of revising behavioral strategies based on current behavioral functioning were not found. Consequently, the rationales as listed on individuals PBSPs were reviewed in a subsequent attempt to identify PBSPs that were revised to due psychologists' review of behavioral data. Overall, of the 14 PBSPs reviewed, no PBSP	

#	Provision	Assessment of Status	Compliance
		(0%) contained a rationale that indicated the PBSP was revised due to review of current behavioral data. This estimation was challenging to obtain, because four of the PBSPs (29%) did not include a "rationale" section. In addition to the finding noted above, the two examples of inadequate monthly PBSP notes are provided below in an attempt to highlight continued areas of concern found in some cases. For example: ▪ The monthly PBSP note for Individual #185 for June 2012 offered no information beyond what was already graphed, offered information that did not make sense (e.g., "another good week for [Individual 185]… behavior rate"), offered subjective impression of inter-observer agreement (IOA) or integrity without actual data (e.g., "data seems to be reliable" or "staff followed PBSP,") and was completed as evidenced by signature and date several months late. ▪ The monthly PBSP notes for Individual #241 (i.e., June and August 2012) were missing substantial amounts of data. For example, the June note did not graph any June data, and appeared to be completed in mid-July (as evidenced by signature and date). Therefore, the psychologist was signing off on data (through the end of May) in mid-July. It was unclear, consequently, what the Psychologist was referring to in her note "[Individual #241] had very few incidents of SIB this month." Similar missing data was evident in the August 2012 PBSP monthly note where only the first week of August was graphed. It was unclear, again, what the Psychologist was referring to in her note that "[Individual #241] had a low rate of SIB this month. His engagement in appropriate communication increased from last month." In general, monthly PBSP progress notes continued to show improvement. This improvement included the noted progress in the use of appropriate graphing conventions (more specific information regarding noted improvement in graphing conventions is provided with regard to Section K.10). The current review of monthly PBSP progress notes also evidenced descriptions of IOA and treatment integrity, sometimes with actual data, across some of the individuals reviewed. Currently, documentation provided evidenced the collection of more IOA and integrity data since the Monitoring Team's last visit. However, the documentation did not include analysis of this data (further information is provided with regard to Section K.10). At the time of the Monitoring Team's present visit, it was noted that the Facility no longer supported the development and implementation of Safety Plans for Crisis Intervention (SPCI). In place of SPCIs, IDTs now facilitated the development of Crisis Intervention Restraint Plans as part of the ISP. That is, these plans were integrated within the ISP in the form of restraint ISP action plans. This change in LBSSLC restraint policy was completed to ensure consistency with State Office policy. To examine the nature of data	

#	Provision	Assessment of Status	Compliance
		collection methods typically utilized to summarize, monitor, and review progress on the implementation of crisis intervention restraint plans, a sample of three individuals with crisis intervention plans were selected and recent Monthly PBSP progress notes (from the last three months) were reviewed. These three individuals included Individual #27, Individual #61, and Individual #124. Based on the documentation provided, dated 10/4/12, this sample reflected 43% of the total (N=7) number of active crisis intervention plans. Of the three individuals sampled, three (100%) evidenced data on restraint use (frequency data) within the sampled monthly PBSP progress notes. Overall, the standard methodology for data collection, monitoring and review continued to reflect improvement. However, it was still not consistently evident when examining Monthly PBSP Notes that the system promoted an accurate and timely process for the majority of individuals in supporting 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, progress was once again noted in the 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 completed or updated at least annually. This requirement included the inclusion and review of data from the most recent Inventory for Client and Agency Planning (ICAP) evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years, or sooner, if significant events appeared to impact adaptive functioning. In an effort to examine the nature of current standardized psychological assessments, a sample of 16 individuals who had ISP meetings within the last six months was selected and their most recent psychological assessment was reviewed. Given the current census of 211 individuals, this sample reflected approximately 8% of the total number of psychological assessments currently in place. Of those individuals sampled, 16 (100%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. Documentation also indicated that 16 (100%) of those sampled had an ICAP completed within the last three years. Of the psychological assessments reviewed, 13 (81%) included results of previously completed standardized tests of intelligence. These tests included, for example, the use of the Wechsler, Slosson, and/or Leiter. In addition, three (19%) contained results of previously completed developmental inventories, including the Battelle Developmental Inventory and the Developmental Profile II. In addition, of the psychological assessments reviewed, 13 (81%) contained results of previously completed standardized measures of adaptive behavior utilizing either the Vineland Adaptive Behavior Scale or the American Association on Intellectual and Developmental Disabilities (AAMD) Adaptive Behavior	Noncompliance

#	Provision	Assessment of Status	Compliance
		Scales. The remaining psychological assessments included the use of the ICAP as the only measure of adaptive behavior. In general, the sample appeared consistent with the Monitoring Team's previous reviews. That is, psychological assessments contained sections targeting specific content areas consistently across reports. Typically, 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 seven (44%) of the assessments reviewed. As observed during the Monitoring Team's previous reviews, in addition to the above targeted areas of assessments, screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment or the completion of the Reiss Screen for Maladaptive Behavior to screen for the need of a psychiatric assessment. The Reiss screenings had been completed to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss Screening process is discussed above with regard to Section J.7 of the Settlement Agreement. According to the "Psychological Assessments/Updates" behavioral services grid, dated 10/2/12, at the time of the Monitoring Team's current visit, psychological assessments had been updated within the past 12 months for 100% of the individuals served by the Facility. In addition, since the Monitoring Team's last visit, it appeared that new testing (either intellectual or adaptive behavior) had been conducted with 22 individuals. This included the completion of both standardized intellectual tests and adaptive behavior scales for 10 individuals. The results of these updated standardized tests were included within a more comprehensive assessment entitled a "Psychological Evaluation." This evaluation was different than psychological assessments. In an attempt to examine the nature of this assessment process, a sample of five individuals who had psychological evaluations completed since the Monitoring Team's last visit was reviewed. Given the number (N=10) of psychological evaluations completed since the Monitoring Team's last visit, this sample reflected approximately 50% of those recently completed. In general, these evaluations contained sections targeting specific content areas, including the rationale and previous assessment findings, as well as information on an individual's history, mood/affect, cognitive and adaptive functioning; review of behavioral functioning, including specific content regarding the PBSP; diagnoses/level of functioning; and recommendations. General findings or information regarding an individual's history, in some cases, included specific sections on medical, physical, and/or psychiatric status, as well as findings from related	

#	Provision	Assessment of Status	Compliance
		assessments from other disciplines (e.g., Occupational Therapy, Speech Language Therapy, etc.). In addition, more detailed findings of completed standardized intellectual tests, scales of adaptive behavior, and ICAPs were included within the section on cognitive and adaptive functioning. In short, this evaluation appeared to be a more robust version of the annually completed psychological assessment. In addition to the completion of annual psychological assessments and the more comprehensive psychological evaluations, functional assessments [previously titled "Structural and Functional Assessment Reports" (SFAR)] were also completed. Indeed, according to the Facility, the primary standard assessment procedure that allowed for the identification of medical, psychiatric, environmental, and other reasons for target behaviors was the structural and functional assessment. As described in the Monitoring Team's previous reports, individuals who received behavioral and/or psychopharmacological interventions were required to have a functional assessment. Currently, according to the behavioral services tracking grid, dated 10/4/12, approximately 99% of individuals with PBSPs had a functional assessment completed (not necessarily an updated one as is discussed below with regard to timeliness). That is, two individuals (i.e., Individual #30 and Individual #20) did not currently have a functional assessment completed. It appeared that Individual #30 was admitted recently to the Facility, and his assessment had not been completed. It was unclear why Individual #20 did not have a completed SFAR or functional assessment. In general, this finding reflected an improvement compared to the Monitoring Team's previous review that, at that time, found missing functional assessments for four individuals (i.e., Individual #20, Individual #22, Individual #57, and Individual #92). Currently, it was noted that the Facility had made progress in revising the SFAR format with reportedly several revisions since the Monitoring Team's last visit. The most recent revision was the rubric entitled "Structural and Functional Assessment" (SFA). One change included a Reason for Assessment section. In addition, a new rubric entitled the "Structural and Functional Assessment (SFA) Review" recently was developed to assist Psychologists in determining whether or not to revise the current functional assessment. As presented in the Monitoring Team's previous report, this rubric offered the opportunity for psychologists to consider the various factors that might necessitate a re-evaluation and completion of a SFA and ultimately to make informed, data-based decisions. To examine the nature of these current assessments, 14 individuals with ISP meetings completed within the last six months and with PBSPs were selected. This sample of individuals reflected 10% of the total number of individuals with PBSPs (N=136). Review of documentation indicated that a SFAR or SFA was only provided for 11 (79%) of the 14 individuals selected. That is, the SFA for Individual #30, a new admission, was	

#	Provision	Assessment of Status	Compliance
		currently "in progress," and was not provided. The initial SFAs for Individual #125 and Individual #114 were not provided for review. However, an SFA Review was provided for Individual #125 (dated 9/21/12) and an SFA Update was provided for Individual #114 (dated 6/7/11). Therefore, an SFAR, SFA, or SFA update/review was provided for 13 (93%) of the 14 individuals selected. With regard to timeliness, of the 14 individuals selected for review, 13 (93%) had a SFAR, SFA, or SFA Review (or SFA update) provided as evidence for the current review. The exception was Individual #30. Of the 14 individuals selected for review, 10 (71%) had a SFAR, SFA, or SFA Review completed within the last 12 months. The exceptions were Individual #185, Individual #114, Individual #241, and Individual #30. SFA Reviews (or updates) were completed for Individual #73, Individual #114, Individual #251, and Individual #125. Overall, based on review of the most recent behavioral services tracking grid, dated 10/4/12, it appeared that approximately 41 (31%) functional assessments were outdated (i.e., recorded completion date exceeded 12 months of current date) compared to the 15 (11%) that were reported as outdated in the Monitoring Team's previous report. Of the 11 SFARs or SFAs that were available for review, four (36%) were completed using the most recent SFA rubric. These included those for Individual #61, Individual #7, Individual #315, and Individual #201. In general, all of the older SFARs had a section for applicable history, including the review of the current PBSP, as well as medical and psychiatric status. Although the new format did not contain a similar section, this information was integrated within other sections. All of the reviewed SFARs or SFAs described both direct and indirect assessment procedures, including interviews, behavior rating scales, direct observation, and/or review of observation notes. Also, preferences (potential reinforcers) were identified in all of the assessments reviewed. In addition, all of the sampled assessments highlighted assessment findings related to setting events or motivating operations, antecedents, consequences, and potential underlying function(s) of target behaviors. All of the assessments also contained a summary section that included discussion of likely functions(s) and potential replacement behaviors. Lastly, all the assessments included recommendations. The current review of sampled functional assessments evidenced continued improvement in quality. The new SFA format appeared much more concise and user-friendly, and included required elements. That is, in addition to the sections identified above, the SFA more clearly examined the extent to which challenging behavior(s) was learned or a product of medical/psychiatric disorders in a discrete "derivation" section within the revised rubric. In addition, the new form allowed the identification of specific individual limitations or needs and the necessary accommodations.	

#	Provision	Assessment of Status	Compliance
		The continued improvement in the quality of functional assessments might be due to the continued use of the Structural and Functional Assessment Self-Monitoring Checklist. As described in the Monitoring Team's previous report, this rubric was designed to be used as both a self-monitoring tool to assist authors in developing adequate and complete SFARs as well as a checklist by peer reviewers during BSC. It appeared that it was helpful to psychologists in assuring that technological requirements were met. Overall, it appeared that this checklist and associated process continued to promote a high level of quality and should continue to be utilized when developing and reviewing SFARs. Overall, quality had appeared to improve. However, the timely completion of SFA and/or SFA Reviews continued to be problematic. In addition, only a small percentage of the current SFAs were in the new format. In order for this section of the Settlement Agreement to be in compliance, in addition to concerns related to the psychological assessments discussed above, these remaining concerns related to the SFAs need to be addressed.	
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, progress was noted in ensuring that each individual had a current, accurate and complete psychological assessment. As previously reported in Section K.5, in an effort to determine whether or not psychological assessments were based on current, accurate and complete clinical and behavioral data, a sample of 16 individuals who had an ISP meeting within the last six months was selected and their most recent psychological assessments were reviewed. Given the current census of 211 individuals, this sample reflected approximately 8% of the total number of psychological assessments currently in place. Of those individuals sampled, 16 (100%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. In most cases, psychological assessments were completed prior to the ISP meeting. That is, 14 (88%) of the assessments were completed prior to the ISP meeting. The exceptions were assessments for Individual #276 and Individual #280 that were completed after the ISP meeting. Documentation also indicated that 16 (100%) of those sampled had an ICAP completed within the last three years. It should be noted that, for three individuals (i.e., Individual #73, Individual #276, and Individual #30), the ICAP reported in the psychological assessment was not the most current ICAP completed. That is, more recently completed ICAPs for these individuals were included within the documentation provided. It was unclear why these ICAPs were not completed earlier to allow the findings to be integrated into the most current psychological assessment. Of the psychological assessments reviewed, 13 (81%) included results of previously completed standardized tests of intelligence and three (19%) contained results of previously completed developmental inventories. Of these, five (31%) were completed within the last five years. In addition, of the psychological assessments reviewed, 13	Noncompliance

#	Provision	Assessment of Status	Compliance
		(81%) included results of previously completed standardized tests of adaptive behavior (not including the ICAP). Of these, five (31%) were completed within the last five years. As noted within the Monitoring Team's previous report, a revised caseload structure was initiated last year with the intent of improving the completion rate of standardized tests of intelligence and adaptive behavior. In addition, a grid had been developed to track the completion of new psychological testing and facilitate adherence to established expectations. At that time, it appeared that new standardized intellectual testing and adaptive behavior scales had been completed for four individuals since the caseload re-structuring. Overall, at that time, it appeared that new testing (either intellectual or adaptive behavior) had been conducted with 11 individuals within the last 12 months. Since the Monitoring Team's last visit, according to the Record of New Psychological Testing, dated 9/21/12, it appeared that both new standardized intellectual tests and adaptive behavior scales had been completed for 10 individuals. In general, since the Monitoring Team last visit, it appeared that new testing including either intellectual or adaptive behavior had been conducted with 22 individuals. Overall, although progress continued to be observed in ensuring annual review of psychological assessments, as well as in the completion of more recent standardized tests of intelligence and adaptive behavior, the majority of assessments continued to be outdated. Consequently, 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, 16 (100%) had a psychological assessment that, at the time of the Monitoring Team's onsite visit, was updated within the last 12 months. Documentation also indicated that 16 (100%) of those sampled had an ICAP completed within the last three years. In addition, 13 (81%) included results of previously completed standardized tests of intelligence and three (19%) contained results of previously completed developmental inventories. Of these, five (31%) were completed within the last five years. In addition, of the psychological assessments reviewed, 13 (81%) included results of previously completed standardized tests of adaptive behavior (not including the ICAP). Of these, five (31%) were completed within the last five years. As presented with regard to Section K.5, according to the "Psychological Assessments/Updates" behavioral services grid, dated 10/2/12, at the time of the Monitoring Team's current visit, psychological assessments had been updated within the past 12 months for 100% of the individuals served by the Facility. Off-site comparison of this summary data with sampled documentation (provided for selected individuals as described with regard to Sections K.5 and K.6 above) reflected 100% correspondence between the dates listed and the sampled documents provided for review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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, three individuals (i.e., Individual #30, Individual #27, and Individual #40) were admitted to the Facility since the Monitoring Team's last visit. Of these, three (100%) had a psychological assessment completed within 30 days of admission. More specifically, for two individuals (i.e., Individual #30 and Individual #27), a "psychological admission summary" was completed prior to admission utilizing information obtained from previous records and interviews of care providers. For the third individual (i.e., Individual #40), a "30 day psychological summary" was completed after admission utilizing information obtained from previous records (admission packet), as well as current home logs and observation notes. It should be noted that, although important information regarding the individual was included in the assessments, at the time of admittance, no new standardized testing was required (i.e., all tests were within five years of the date of admittance). However, at the time of the onsite visit, the date of the most recent standardized intellectual testing was current for only two (67%) of the three individuals. That is, the date provided for the most recent intellectual testing for Individual #30 appeared to have exceeded five years. No updated psychological assessment was provided to the Monitoring Team for review and review of summary data (i.e., as listed on the "Record of New Psychological Testing, as of 09/21/2012") only evidenced a date for recent adaptive behavior testing (i.e., no date was provided for updated IQ testing). Therefore, evidence did not reflect completion of the one intelligence test that went out of date following admission. Overall, documentation revealed that all sampled individuals, as well as all of the individuals served at LBSSLC, as reported, had a psychological assessment dated within the last 12 months. This high level of completion was reportedly due to improved administrative oversight by the Assistant Director of Behavioral Services. Indeed, documentation provided evidenced individual meetings with psychologists in March, April, and July 2012 at which such issues were discussed. Although this timely review reflected significant progress, the Facility will need to continue to complete more updated 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	Progress was noted in the provision and monitoring of psychological services other than PBSPs, including counseling supports. Findings within the Monitoring Team's previous report noted that Behavioral Services staff had assumed primary responsibility for developing counseling treatment plans, as well as monitoring and graphing progress of performance on counseling targets. At that time, it was observed that a standardized format (i.e., SAP format) for counseling treatment plans was developed, and in addition to developing these plans, psychologists	Noncompliance

#	Provision	Assessment of Status	Compliance
	efficacy of treatment.	facilitated the collection of session notes and were responsible for ongoing progress monitoring using data tracking sheets (i.e., SAP data sheets). Overall, these changes appeared to facilitate improved quality of plans and progress monitoring for some of the individuals previously reviewed. Currently, based on verbal report and documentation provided, dated 10/4/12, it appeared that three off-campus community counselors provided community-based counseling services to seven individuals. To examine the nature of these psychological services, counseling treatment plans (i.e., "Counseling Skill Acquisition Program") as well as monthly progress notes and session notes, for the last three months, were reviewed for three individuals currently receiving counseling supports. This sample represented 43% of those individuals currently receiving counseling services. Of the three individuals, the following was found: ▪ Three (100%) had counseling treatment plans; ▪ Three (100%) had treatment plans in which one or more treatment objectives were identified. However, for only one of the three (33%), the objectives were adequately defined. In addition, for only one individual (33%), treatment objectives in the counseling plans were consistent with the target or replacement behaviors in the PBSP. More details are provided below; ▪ Three (100%) had treatment plans with general descriptions of the treatment methodology; ▪ Three (100%) had treatment plans with definitions of "marker behaviors," which appeared to represent target or replacement (alternative) behaviors; ▪ Three (100%) had treatment plans that conspicuously identified a setting and schedule for counseling sessions; ▪ Three (100%) had treatment plans that specified data collection procedures; ▪ None (0%) of the plans set forth adequate generalization methods. This is discussed further below; ▪ Two (67%) had monthly progress notes completed for all months where counseling sessions were completed; and ▪ Two (67%) had a weekly sessions note completed for each week counseling sessions were completed. Overall, the sampled plans, monthly progress notes, and sessions notes appeared to be an improvement over those reviewed previously. It appeared that the counseling treatment plans as well as the monthly counseling progress notes were standardized across individuals sampled, and this structure facilitated a more consistent and higher quality document. Although progress appeared to be evident in the quality of counseling treatment plans and ongoing monitoring, concerns continued to be noted. That is, the operational definitions of marker behaviors for Individual #34 and Individual #121 were vague. Although this definition might be intentionally broad by design, it seemed	

#	Provision	Assessment of Status	Compliance
		potentially problematic for other staff (i.e., psychologists, direct support professionals) to identify and monitor as these strategies were integrated (generalized) into home and work settings. The provision of examples for each marker behavior might increase the likelihood that non-clinical staff could prompt and/or recognize these responses. In addition, treatment plans included a treatment objective(s) as well as several components that were identified to assist with the measurement of treatment effectiveness. These included attendance at sessions, graphing of marker behavior, summary of therapists' comments, progress review, and recommendations for revision. It appeared that session attendance was an important consideration as a foundation to treatment success. However, it was unclear whether or not marker behaviors were graphed for Individual #34 and Individual #121, because monthly PBSP progress notes were unavailable. In addition, the operational definitions provided did not correspond with those identified as target or replacement behaviors in the PSBPs for Individual #34 and Individual #121. Lastly, it was unclear to the Monitoring Team how all of the sampled treatment plans were planning for generalization. That is, statements referring to "generalization" in the treatment plans were incomprehensible to the Monitoring Team. Documentation also evidenced training for psychologists and QDDPs targeting barriers to counseling or other psychological services (dated 9/17/12). This training appeared to be comprehensive and covered issues related to selection of evidenced-based counseling practices, the therapeutic environment, consistent attendance at counseling sessions, involvement of the counselor in the IDT, progress monitoring, and other issues related to the effectiveness of treatment. 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, that methodology and strategies 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. Recently, a survey was completed to identify interventions that might lack empirical support. According to documentation provided, various treatments (e.g., sensory diet, body sock, sensory room) were identified for four individuals. In response, the Facility planned to develop methods to measure the efficacy of these treatments. The results of these assessments will need to be examined at the Monitoring Team's next review. The current recommendation of the Monitoring Team remains consistent with the Monitoring Team's previous reports. That is, the Facility is encouraged to collect data	

#	Provision	Assessment of Status	Compliance
		and determine if these services and supports are effective for individuals for whom they were prescribed. The Facility remained out of compliance with this provision. Continued improvement and consistency in quality of counseling treatment plans as well as evidence of consistent and adequate data collection, monitoring, and review of these services needs to be evident.	
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 the development of quality PBSPs. As noted in the Monitoring Team's previous report, sampled PBSPs appeared comprehensive, typically adhered to a standardized format, and consistently included many of the elements critical to effective behavioral programming. However, observations at that time revealed there were components that were somewhat inconsistent and inadequate and, consequently, did not meet the requirements of the Settlement Agreement. At that time, it was noted that a newly revised streamlined PBSP format had been developed. As described below, the current review did find the new format much more concise and user-friendly than previous formats. It an attempt to examine the quality of PBSPs, a sample of 14 individuals who had ISPs within the last six months and who also had PBSPs was selected. Based on the behavioral services tracking grid, dated 10/4/12, these 14 PBSPs represented 10% of the total number of PBSPs (N=136) currently in place. In addition, nine of the selected individuals had PBSPs updated since the Monitoring Team's last visit. This represented approximately 13% of all the plans (N=71) completed since the last visit. In addition, of the 14 PBSPs, 13 (93%) had been updated within the last 12 months. The exception was the PBSP for Individual #185, dated 6/30/11. Of the 14 PBSPs, six (43%) were completed using the most recent PBSP format. These included the PBSPs for Individual #251, Individual #125, Individual #61, Individual #30, Individual #7, and Individual #315. In an effort to provide the most effective review of the Facility's most recent efforts to improve the quality of PBSPs, only these PBSPs developed using the most revised format were examined. The results of this review are reported below. It should be noted that second page of the PBSP for Individual #315 was not provided for the current review. The newly revised PBSPs for six sampled individuals was examined and the following was found: ▪ Five (83%) were based on completed functional assessments. The exception was Individual #30 who was recently admitted; ▪ Two (33%) included a rationale for development or revision of the PBSP; ▪ Six (100%) included operational definitions of target behaviors;	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Five (83%) included operational definitions of replacement behaviors. However, concerns were noted with the adequacy of these definitions for Individual #30 and Individual #251. As a result, only three (33%) included adequate operational definitions; ▪ Four (67%) included operational definitions of other "monitored" or alternative behaviors that facilitated ongoing monitoring of symptoms of underlying conditions and review of medication; ▪ Six (100%) included the purpose of the plan, specific interventions or strategies, including underlying function(s) of target behaviors; ▪ Six (100%) included behavioral objectives for target behaviors. However, concerns were noted for Individual #7. As a result, only five (83%) included adequate behavioral objectives for target behaviors; ▪ Five (83%) included behavioral objectives for replacement behaviors. That is, no replacement behavior was identified for Individual #30. Concerns were noted for Individual #251, Individual #61, and Individual #7. As a result, two (40%) included adequate behavioral objectives for replacement behaviors; ▪ Three (50%) had one or more SAPs developed to address the acquisition of replacement or alternative behaviors; ▪ Six (100%) included antecedent-based or preventative strategies; ▪ Five (83%) included consequence-based strategies. The exception was Individual #315, where this information was unavailable for review (second page was missing); ▪ Six (100%) appeared to include the use of positive reinforcement. However, problems were noted for Individual #251 and Individual #7. Therefore, it was adequately included for four individuals (67%); ▪ Five (83%) included directions on data collection. The exception was Individual #315, where this information was unavailable for review (second page was missing). However, directions were vague for Individual #30 and #7 regarding the dimension of the target behavior being tracked compared to the other Individuals where specification was provided; ▪ Five (83%) included revision criteria. The exception was Individual #315, where this information was unavailable for review (second page was missing); ▪ Two (33%) included strategies to reduce the intrusiveness of the PBSPs; and ▪ Five (83%) included the formatting and directions for conducting integrity checks. Overall, the revised PBSP format appeared to be a vast improvement over previous formats. The sampled plans were all similarly structured, two pages in length, and very concise and user-friendly. Definitions were easy to find, and the purpose, which highlighted underlying function(s), was conspicuous and likely helpful to understanding the provided interventions. Antecedent- and consequence-based interventions were	

#	Provision	Assessment of Status	Compliance
		typically presented in order and included the use of positive reinforcement. In some cases, PMAB blocking strategies were noted. In addition, procedures for data collection were found. However, several areas of concern remained. For example, a brief rationale for the development or revision of the plan in general (or specific strategies) was not consistently found. In several cases, the operational definitions for replacement behaviors remained problematic. This included the PBSP where a replacement behavior(s) was not included (i.e., Individual #30) or poorly defined (i.e., Individual #251). Behavioral objectives were unclear or inadequate for target behaviors (i.e., Individual #7) and replacement behaviors (i.e., Individual #251, Individual #61, and Individual #7). For example, the objectives were written to be assessed within one month's time (i.e., Individual #7), were not included for all replacement behaviors (i.e., Individual #251 and Individual #7), or were often based on "number of chances" or "percentages of opportunities." This might work in cases where formal training sessions were planned, but not necessarily for individuals without SAPs targeting replacement behaviors (i.e., Individual #61 and Individual #7). Although the use of positive reinforcement was noted in all of the plans, its use still appeared vague (i.e., Individual #251) and, at times, unclear and counterproductive (i.e., Individual #7). Similarly, although data collection procedures were found, at times the type of data (frequency count, etc.) was not specified. Plans to reduce the intensiveness of behavioral strategies (e.g., one-to-one staffing following target behaviors for Individual #7) were often not found in PBSPs (with exceptions of Individual #251 and Individual #125). Lastly, revision criteria, although found in all sampled PBSPs, was not standardized. That is, the Facility might want to identify a standardized approach to determining when to review PBSPs. More specifically, the Facility might want to consider using a standardized time line for when review of individualize success or fail criteria are reviewed. Currently, these timelines appeared somewhat random in the sampled plans. A more consistent expectation might be helpful for psychologists in trying to determine when to review individualized criteria. Although, the Monitoring Team recognizes individualization is important and this general expectation might not be appropriate for everyone, a general guideline to assist psychologists in determining when to review revision criteria would likely be helpful. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the sampled PBSPs, as well as to determine if plans were implemented in a timely manner once consent was obtained, the dates of consent, approval and implementation of the sample were examined on the behavior services grid, dated 10/4/12. More specifically, dates of the 14 sampled individuals, including the BSC approval date, HRC approval date, date of consent of the guardian or Facility Director, and the implementation date of the PBSP, were examined. According to the dates provided, necessary consents were obtained prior to the implementation of the PBSP for approximately 11 (79%) of those individuals sampled. More specifically,	

#	Provision	Assessment of Status	Compliance
		according to the tracking grid: the PBSP for Individual #185 appeared to be implemented prior to HRC approval; the PBSP for Individual #276 appeared to be implemented prior to guardian and director approval; and, the PBSP for Individual #201 appeared to be implemented prior to BSC and HRC approval. It should be noted that determining whether or not required consents were obtained prior to the implementation of the PBSP was challenging, because dates were missing (e.g., implementation date for Individual #30). In addition, of those sampled, 13 (93%) PBSPs were implemented within 14 days of receiving necessary consent. Overall, based on the tracking grid, 100 (73%) of all active PBSPs met the 14-day criteria. In addition, of those sampled, 12 (86%) received necessary consents within 30 days of plan development. Overall, based on the tracking grid, 98 (72%) received necessary consents within 30 days of plan development. Although progress had been made, the Facility remained out of compliance with this provision. In addition to continuing to improve the quality of PBSPs, focus also was needed to obtain timely consents and approvals for the plans, and obtain them prior to implementation of the plans.	
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 continued to be evident in the area of data collection and data review. In addition, as noted below, efforts to improve the graphing of data, as well as collect inter-observer agreement and competency/treatment integrity data had improved as well. As presented in the Monitoring Team's previous report, behavioral data was no longer displayed within psychological or functional assessments and intervention plans, and as a result, the previous review targeted only PBSP progress notes. To examine the nature of data display typically utilized to summarize, monitor, and review progress, a sample of 14 individuals who had an ISP meeting within the last six months and who also had PBSP was selected and reviewed. Based on the behavioral services tracking grid, dated 10/4/12, this sample reflected 10% of the total number (N=136) of active PBSPs. 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 sampled documentation indicated that all 14 (100%) individuals had Monthly PBSP Progress Notes completed across the last three consecutive months (June, July and August). At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 14 (100%) of the individuals sampled. However, target and replacement (alternative) behaviors were consistent across the PBSP and monthly PBSP progress notes for only seven (50%) of the individuals sampled. That is, inconsistencies were found between the PBSP and monthly PBSP progress notes for either the target or replacement behaviors as defined in the PBSP and graphed on the progress note. These inconsistencies were noted for Individual #73, Individual #279, Individual #251, Individual #125, Individual #61, Individual #7, and Individual #201.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monthly progress notes for 13 (93%) individuals included weekly graphed data for each identified month. The one exception was the monthly notes of the June and August for Individual #241 that were missing the majority of weekly data for each month. Indeed, several of the clinician notes within the sampled progress notes indicated concern about missing data (e.g., "data collection remained poor" as reported in the August 2012 monthly PBSP progress note for Individual #201). Further review of PBSP monthly progress notes revealed that Y- and X-axes were adequately labeled for 14 (100%) of the notes reviewed. However, only nine (64%) of the sampled individuals had graphs that were easily interpretable. That is, concerns remained regarding the continued use of extreme ranges on Y-axes that made interpretation of all graphed data difficult (e.g., Individual #7, Individual #201, and Individual 315), as well as the use of very similar markers across different behaviors, making identification and discrimination of data paths difficult (i.e., Individual #73, Individual #135, and Individual #315). Monthly progress notes also evidenced the use of condition change lines or other demarcations on the graph to illustrate changes in medication or other variables in 10 (71%) of the individuals' sampled monthly notes. The exceptions included Individual #30, Individual #135, Individual #241, and Individual #125, where these interpretive aids were not utilized. Lastly, verbal reports from the Director of Behavioral Services indicated an effort to include findings of inter-observer agreement probes as well as integrity checks within monthly PBSPs progress notes. Review of monthly notes evidenced discussion of IOA or Integrity in 12 (86%) of the sampled individual's monthly notes. However, actual IOA or integrity data was presented in only nine (64%) of those reviewed. Indeed, when data was presented, it was primarily IOA data. That is, IOA and integrity data was reported in eight (57%) and two (14%) of individual's monthly progress notes, respectively. Overall, the quality of monthly PBSP progress notes continued to improve as evidenced by findings of the current review. It was evident the behavioral services staff had expended substantial effort in improving the nature of this monitoring system through ongoing oversight and feedback. Indeed, documentation (i.e., "2012 Progress Notes") reflected the ongoing review of monthly notes for most of the individuals served by LBSSLC. That is, evidence was provided of the regular review of monthly progress notes for individuals with PBSPs by behavioral services staff. Documentation evidenced continued collection of inter-observer agreement data since the Monitoring Team's last visit. Previous reports have documented the Facility's efforts at collecting IOA data and reported that a total of approximately 65 IOA probes across 13 residential sites were completed 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	

#	Provision	Assessment of Status	Compliance
		IOA probes during a four-month period. Currently, based on a listing of 2012 IOA probes, approximately 337 IOA probes across 14 residential sites were completed between April 2012 and September 2012. Based on the verbally reported expectation that 10 IOA probes would be completed within each residence per month, this reflected the completion of approximately 40% of the expected number of IOA probes during a six-month period. This finding reflected a substantial improvement in the completion of IOA. In addition to the collection of IOA data, documentation evidenced collection of competency/integrity checks since the Monitoring Team's last visit. Currently, based on a listing of 2012 Competency/Integrity Checks, approximately 496 competency/integrity checks across 15 residential sites were completed between April 2012 and September 2012. Based on the reported expectation that one treatment integrity check would be completed for each PBSP per month, this reflected the completion of approximately 61% of the expected number of integrity checks over a six-month period (i.e., 136 PBSPs over a six-month period = 816 integrity checks). Documentation indicated that two competency/integrity formats were currently utilized. This was necessary due to many of the active PBSPs not currently being written according to the new format. In general, since the Monitoring Team's previous review, the Facility had evidenced significant improvement in the facilitation of processes designed to collect and track IOA and integrity data over time by individual, residence, rater, and shift. That is, tracking spreadsheets were simplified and re-implemented in June 2012. Current reports indicated that outcome data of IOA probes and competency/integrity checks had been summarized for June, July, and August 2012. More specifically, summarized outcome data indicated that Behavioral Services Department staff were monitoring the number of IOA probes (across both target and replacement behaviors), as well as the resulting IOA estimates. Currently, reported IOA estimates reflected a high level of agreement with scores ranging between 67 to 100% and 83 to 100% for target and replacement behaviors, respectively, across June, July, and August 2012. Summarized outcome data also indicated that Behavioral Services staff were monitoring the number of competency/integrity checks completed across June, July, and August 2012. Currently, reported competency/integrity checks reflected a high level of competence as scores that met criterion (above 80%) were reported for 90%, 80%, and 79% of checks completed in June, July, and August 2012, respectively. In general, improvement in the quality of the Monthly PBSP Progress note continued to be observed. This reflected continued progress over time. In addition, substantial improvement in the collection of IOA and integrity data was observed. The Facility should continue to demonstrate ongoing improvement over time in these areas to reach compliance in with this section of the Settlement Agreement.	

#	Provision	Assessment of Status	Compliance
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 are written so that they can be understood and implemented by direct support professionals. That is, as noted below, progress in the revision of PBSPs as well as in the collection of competency/integrity checks was evident. As previously discussed with regard to Section K.9, efforts to revise the format of PBSPs to improve accessibility, understanding, and implementation by staff had been observed. Indeed, the revised PBSP format appeared to be a vast improvement over previous formats. As noted, the sampled plans were all similarly structured, two pages in length, and very concise and user-friendly. In addition, the plans contained many of the elements necessary for effective behavioral programming. However, concerns regarding the sampled PBSPs were also noted. Currently, of the 14 PBSPs, six (43%) were completed using the most recent PBSP format. Overall, based on information the Facility provided, approximately 39% of active PBSPs were in the streamlined, more staff compatible format. As previously reported this streamlined format was a dramatic departure from previous rubrics and previously included information, including historical information, risks and benefits, and psychotropic medications and side effects, for example, were no longer included. Verbal reports and documentation continued to indicate 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 monitored by behavioral service administrative staff, and when necessary, re-written to meet this criterion. According to the Facility Self-Assessment, readability levels were checked and adjusted, when necessary, for 49 (100%) of the PBSPs reviewed and approved by BSC between 3/23/12 to 8/21/12. At the current time, however, summary data of the readability estimates of all PBSPs was not provided so these estimates could not be confirmed. Integrated within the new streamlined PBSP format was a competency/integrity rubric that was started in late February 2012. The Monitoring Team's previous reports described the process targeting competency and integrity sampling, and when necessary, retraining. As observed in the Monitoring Team's previous report, approximately 125 competency/integrity probes were completed between 2/3/12 and 3/16/12 across all residential programs. Currently, based on a listing of 2012 Competency/Integrity Checks as reported with regard to Section K.9, approximately 496 competency/integrity checks across 15 residential sites were completed between April 2012 and September 2012. In addition, summarized outcome data also indicated that Behavioral Services staff were monitoring the number of competency/integrity checks completed across June, July, and August 2012. Currently, reported competency/integrity checks reflected a high level of competence as scores that met criterion (above 80%) were reported for 90%, 80%, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		79% of checks completed in June, July, and August 2012, respectively. It was still unclear, however, how the actual competency scores were generated, given the fact that these probes did not appear to be formatted or provide directions to produce a total score. This observation was consistent with findings noted in the Monitoring Team's previous report. Indeed, providing a format and directions would likely facilitate the determination a total score, and provide psychologists with a quantitative indicator of competence and treatment integrity. Indeed, this data could then be integrated into monthly PBSP progress notes. That is, as reported with regard to Section K.10, review of monthly notes evidenced that integrity data was only reported in monthly PBSP progress notes for two (14%) of the individuals in the sample. Lastly, the competency/integrity checks did contain directions on conducting inter-rater reliability checks. Although, no documentation or data was provided as evidence that these were being completed. Overall, progress was noted in ensuring PBSPs were written to ensure that staff could understand and implement them effectively. However, the majority of PBSPs were not written in the streamlined format, and competency/integrity checks continued to appear insufficiently complete and required revision. Consequently, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Since the Monitoring Team's last visit, limited progress was noted in the provision of competency-based training. The Monitoring Team's previous reports described the nature of New Employee Orientation (NEO) training, as well as on-the-job-training (OJT). Current verbal reports from the Director of Behavioral Services indicated no significant changes to NEO or OJT related to psychological services. Previous recommendations regarding ensuring that psychologists have sufficient time to train direct support professionals, especially new hires, remained unaddressed. Consequently, the Facility is encouraged to re-examine the amount of time allocated to training PBSPs, especially in residential programs supporting individuals with significant behavioral issues and/or those with higher number of PBSPs. Current efforts at ensuring the competency of behavioral services staff in conducting competency-based trainings continued to involve direct observation of training sessions by the Director and/or Assistant Director of Behavioral Services. Although onsite observations evidenced attendance, including performance feedback, by the Assistant Director at two PBSPs trainings completed by two different psychologists, no data regarding the completion of observations for other psychologists was submitted for review. However, direct observation of these PBSP trainings during the recent onsite review revealed efficacious demonstrations of competency-based training. Previous recommendations have targeted the need to ensure that part-time or pulled	Noncompliance

#	Provision	Assessment of Status	Compliance
		direct support professionals received competency-based training. As reported in the Monitoring Team's previous report, efforts to track the training that pulled staff receive prior to working in programs was initiated through the use of a Pull Staff Member Orientation Page. At that time, documentation revealed that this system was trained (in January 2012) and implemented (in February and March 2012) at two residential programs (518 and 513 S. Cedar). Currently, there was some documentation provided as evidence that this system was still in place. However, the provided evidence was not adequate to demonstrate that this system was functioning across campus for all pulled staff. In addition, there was no evidence to indicate that the staff providing the training to part-time or pulled direct support professionals were judged to be competent trainers. As recommended in the past, the Facility should ensure that key professional and support staff (e.g., Psychological Assistants, Home Team Leaders, Assistant Home Team Leaders, Residence Coordinators, QDDPs), who are most likely to be in positions to model accurate and effective programming (i.e., skill acquisition plans, PBSPs, SPCIs, data collection, etc.) to direct support professionals, are trained first. This group could also 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. The Monitoring Team's previous reports highlighted the administrative oversight provided to ensure adequate attendance at mandatory trainings. As previously noted, 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 the Director of Behavioral Services and the Director of Residential Services, this process was still in place and continued to be helpful in promoting attendance at trainings. However, although this process might be implemented informally, it was unclear if any formal tracking systems were in place to monitor each staff member's attendance at trainings for each of the individuals they were assigned to support. That is, other than completed training documentation (e.g., staff signatures on the "Certification of Completion of Competency Based Training") or completed competency-integrity checks, there did not appear to be any systematic tracking process in place to monitor the training of direct support professionals, including the training of pulled or relief staff, across all those individuals for whom they were responsible for providing supports. Estimates of completed PBSP trainings appeared to be completed, according to data provided within Section K.12 of the Facility Self-Assessment. However, these estimates did not appear to examine which staff were or were not trained. In addition, although the Facility Self-Assessment included related data, as noted above, documentation was not provided of an adequate system to track the staff that were or were not trained.	

#	Provision	Assessment of Status	Compliance
		Lastly, as presented with regard to Sections K.9 and K.11, progress was evident in the increasing completion of competency/integrity probes since the Monitoring Team's last visit. Currently, reported competency/integrity checks reflected a high level of competence as scores that met criterion (above 80%) were reported for 90%, 80%, and 79% of checks completed in June, July, and August 2012, respectively. It was still unclear, however, how the actual competency scores were generated given the fact that these probes did not appear to be formatted or provide directions to produce a total score.	
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. Of these 11 staff, two psychologists were currently BCBAs. In addition, reports indicated that two additional Psychological Assistants recently had been hired for a total of seven Psychological Assistants. Currently, there was one vacant Psychological Assistant position. Recent reports, as of 10/1/12, indicated that LBSSLC currently served 211 individuals. Based on this current census, and the recognition that the Director and Assistant Director of Behavioral Services did not officially carry a caseload, an approximate average ratio of 1:23 psychologist-to-individual served was determined. With seven Psychological Assistants currently employed, the Facility exceeded the ratio of one Psychological Assistant for every two Psychologist/Associate Psychologists. The Facility was rated as being in noncompliance with this provision because the professionals within the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as required by this provision, as evidenced by the absence of professional certification, as well as by the overall quality of the programming observed at the Facility.	Noncompliance

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

1. The Facility should ensure the adequacy of required supervision according to the Behavior Analyst Certification Board (BACB) supervision guidelines to eligible behavioral services staff. (Section K.1)
2. The Facility should continue to ensure adequate attendance by key members (e.g., psychiatry, nursing, etc.) in accordance with established expectations (monthly attendance), at BSC meetings. (Section K.3)
3. The Facility should ensure that meeting minutes (e.g., including who attended in person or by phone, content of review, etc.) accurately reflect the external peer review process. (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. The Facility should ensure that 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)

6. When discussing missing data in monthly notes, the Facility should quantify the amount of missing data and offer an explanation and response. (Section K.4)
7. The Facility should ensure that monthly notes, when discussing IOA or integrity-competency checks, include relevant data (i.e., number of probes conducted, estimated agreement, etc.). (Section K.4)
8. 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. (Section K.4 and K.5)
9. The Facility should ensure the continued progress in updating standardized tests of intelligence and adaptive behavior scales. (Section K.6 and K.7)
10. 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 collected objective data. (Section K.8)
    b. Clear behavioral definitions and 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. (Section K.8)
    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. (Section K.8)
    d. 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)
11. The Facility should continue to identify the use of non-evidenced based practices. (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 of improvement on which the Facility should focus include:
    a. Description of rationale;
    b. Specification of previously attempted interventions, if applicable;
    c. Operational definition of replacement behaviors;
    d. Complete behavioral objectives that facilitate efficient and accurate progress determination, especially for identified replacement behaviors;
    e. Conspicuous integration of robust reinforcers (beyond verbal praise) within antecedent and consequence-based strategies, including highly preferred reinforcers that, to the extent possible, are stimuli that are most easily sustained in the natural environment. If more artificial reinforcers are utilized, plans for fading their use would be necessary once desired skills are acquired and maintained;
    f. Specification of type of data collected (frequency, duration, etc.); and
    g. Standardization of plans or considerations, if applicable, to reduce the intensity of identified interventions. (Section K.9)
14. The Facility should continue to monitor the behavioral services tracking grid to ensure collection of necessary consents and approvals for behavioral programming prior to their expiration and/or implementation, as well as ensure timely implementation once consent has been obtained. (Section K.9)

15. The collection of inter-observer agreement data should continue, including continued use of the developed tracking system to ensure adequate collection across probes, across residences, raters and shifts, for example. In addition, outcome data should be graphed as well. (Section K.10)
16. 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 and distinguishable;
    c. Remove additional legend markers if not in use. (Section K.10)
17. The collection of PBSP competency/integrity training assessments should continue, including inter-rater reliability assessments estimates. In addition, the Facility should develop a tracking sheet to assist with ongoing monitoring and analysis of process and outcome data. (Section K.10)
18. The Facility should re-examine the format of competency/integrity checks and provide directions that would allow staff to determine an overall score. (Section K.11)
19. The Facility should ensure the adequate completion of competency/integrity checks. (Section K.11)
20. The Facility should re-examine the amount of time provided to train new staff on behavioral programming and ensure that the amount of time is adequate given the expected outcome of the training. (Section K.12)
21. 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)
22. The Facility should consider developing a system to track the competency-based training of 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: ▪ **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 the Monitoring Team's last visit; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing cardiopulmonary resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Any in-service for PCP training on ICD and Diagnostic and Statistical Manual (DSM) diagnostic criteria in last six months; o Since the last onsite review, copy of Continuing Medical Education (CME) for each primary care provider; list of CME credits according to topics reviewed; list per PCP of total CME credits during this time period; o Any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of infection control committee meetings, for the prior six months; o Minutes of skin integrity committee meetings for the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o For any medical staff meetings (e.g., morning medical meetings, etc.), all minutes, handouts, hospitalizations, and 24-hour reports discussed, for 15 days prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including any non-facility physician review reports or data since the Monitoring Team's last visit, and separate reports/data of external medical peer review audits and internal medical peer review audits: external medical provider review, dated 8/22/12; internal medical provider review, dated 8/28/12; LBSSLC Medical Services Department Internal and External Medical Provider Review, dated 8/29/12; Action Plans and QA follow-up (Round #6); Consultant Recommendations Tracking 1/7/12 to 8/21/12; consultant recommendations random audit – August 2012; Medical provider audit in-service (various); and Corrective Actions related to second quarter emergency room visits and hospitalization data, dated 7/26/12; o List of individuals who died since the Monitoring Team's last visit. For each individual, date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory; o Mortality Reviews (i.e., clinical, administrative, and nursing reports), since Monitoring Team's last visit;

	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 death reports (i.e., clinical/administrative) that remain incomplete/outstanding; o Twenty-one (i.e., twenty were requested and twenty-one submitted) most recent annual medical assessments and physical examinations, and prior annual assessment and examinations for following: Individual #151, Individual #7, Individual #293, Individual #15, Individual #193, Individual #175, Individual #108, Individual #322, Individual #211, Individual #321, Individual #279, Individual #79, Individual #290, Individual #265, Individual #304, Individual #125, Individual #298, Individual #112, Individual #62, Individual #149, and Individual #241; o Specialty clinic schedule per month for past six months; o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o For one individual from each residential home, copies of: all consultant reports (i.e., medicine and surgery inclusive of subspecialties), since the Monitoring Team's last visit; and all integrated progress notes commenting on consultant reports (i.e., medicine and surgery inclusive of subspecialties), (i.e., agreeing or reason not agreeing), and any ISP addendum related to the consultant report; o Lists of individuals: ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (e.g., compound, simple, stress, etc.), bone fractured (i.e., location); ▪ With injuries requiring visit to ER or hospitalization, since the last onsite review; and ▪ With pica or ingesting inedible object, date of ingestion, object ingested, and whether taken to ER or hospitalized, since the last onsite review. o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, and list reason for colonoscopy (i.e., preventive versus evaluation of active problem), with reason if not up-to-date; o For those women over 40, date of last mammogram and reason listed if not up-to-date (e.g., guardian refusal, etc.); o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person [including calcium, Vitamin D, intravenous (IV) bisphosphonate, etc.], date of last Dual Energy X-ray Absorptiometry (DEXA) scan or indication if not completed, and copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, any lab work testing for secondary causes (from current active record), or other information indicating cause (specific

	medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, any lab work testing secondary causes (from current active record), or other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (e.g., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down syndrome, date of last thyroid test; o For those going to the ER and not hospitalized, integrated progress notes from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER, and copy of Facility record orders, integrated 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). Information was submitted for the following individuals: Individual #136, Individual #299, Individual #199, Individual #175, Individual #322, Individual #17, Individual #225, Individual #103, Individual #113, and Individual #304; o For the 10 individuals most recently hospitalized that have returned for at least 30 days (in order to allow completion of recommendations), integrated progress notes from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, discharge orders/recommendations from hospital, and Facility record orders, integrated progress notes, and follow-up for any hospital discharge orders and recommendations, including those for: Individual #323, Individual #12, Individual #61, Individual #113, Individual #45, Individual #167, Individual #324, Individual #197, Individual #2, and Individual #90; o For these same 10 most recent hospitalizations that have been completed, hospital liaison nurse documentation of hospitalization; o Length of stay for infirmary admissions for past six months, if applicable; 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) UTIs; and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) 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), including for: Individual #146, Individual #290, Individual #171, Individual #22, and Individual #120; o List of individuals seen by neurologist with dates on which appointments were completed 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 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 Vagus Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals on one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, Felbamate); o Any tracking of data for individuals who have transitioned to community since the Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post Move Monitor and community service coordinator at 90-day transfer; o For the three individuals most recently transitioned to the community for at least 90 days, seven, 45, and 90-day post-move monitoring reports. For these three individuals, copy of the Community Living Discharge Plan (CLDP), most recent ISP, BSP, and subsequent addendums, most recent annual medical exam, and most recent nursing assessment, for: Individual #59, Individual #237, and Individual #221; o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (on campus and off site), list of appointments that were completed and ones not completed (with reasons); o For hospitalizations in prior six months, copies of follow-up ISPAs; o Numbers of individuals with a diagnosis of seizure disorder on no anti-epileptic medications; o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at morning provider/medical meetings for period

	of 30 to 60 days prior to the Monitoring Team's visit, any documents providing evidence of closure (e.g., minutes of medical staff meeting, ISPA addressing concern, etc.); o For the last five individuals to whom pre-treatment sedation was administered for a medical procedure, all information related to medical pre-treatment sedation used, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries. Information submitted for following individuals: Individual #222, Individual #1, Individual #203, Individual #79, and Individual #58; o Ten most recent PNMT recommendations with physician orders; o ISPAs addressing missed appointments or refusals for the past three months for mammograms and colonoscopies; o List of missed medical appointments with reasons past six months; o Presentation Book for Section L; o LBSSLC Quality Assurance Plan, dated 8/29/12; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women age 40 to 70, list of individuals in past three years (with dates) with pap smear with adequate reading, individuals with pap smears insufficient for reading, individuals with pap smears attempted but unsuccessful, and individuals for whom pap smear not indicated with reason provided; o Since 1/1/12, for individuals with pica, names of individuals, date of pica, and item consumed; o For offsite and onsite specialty clinic appointments, number of appointments January to August 2012, number of completed appointments, number of appointments missed due to refusals, number of appointments missed due to non-refusals, and for missed appointments, number of individuals with subsequent completed visits; o Provider morning meeting minutes from 10/1/12 to 10/5/12, including any attachments; o Follow up/closure information to any recommendations from administrative mortality reviews; o Attendance for provider morning meetings, from July 2012 to 9/30/12; o Monthly closure data for morning provider meeting, including: date initially presented, date closed, and brief category or reason, for April through September 2012; o Data from general medical audit and medical management audit from external medical peer review for February 2012, internal medical peer review May 2012, and external medical peer review August 2012; o Number of employees (denominator) for which "Dehydration" training was applicable; and o For each of the following individuals, copies from the active record of the following: DG-1; most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past year of IPNs, lab results, x-rays, scans, Magnetic Resonance Imaging (MRIs), and ultrasound reports; hospital discharge summaries for past one year; ER reports for past one year; consults and procedure reports past one year; DNR forms, if applicable; physician orders past one year; most recent ISP and subsequent

	addendums; most recent BSP; and past three medical quarterly reviews, for: Individual #252, Individual #181, Individual #147, Individual #322, Individual #45, Individual #308, Individual #9, Individual #8, Individual #19, Individual #242, Individual #3, and Individual #2. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shults, RN, Medical Program Compliance Nurse. ▪ **Observations of**: o Individual #323, Individual #258, Individual #37, Individual #312, Individual #226, Individual #217, Individual #136, Individual #6, Individual #195, Individual #43, Individual #293, Individual #181, Individual #281, Individual #17, Individual #211, Individual #225, Individual #176, Individual #171, Individual #304, Individual #104, Individual #9, Individual #167, Individual #196, Individual #191, Individual #62, Individual #139, Individual #324, Individual #185, Individual #21, Individual #215, Individual #78, and Individual #89.
	Facility Self-Assessment: For Section L, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: external medical peer review audit (August 2012), external medical management peer review audit (August 2012), internal medical peer review audit (May 2012), and internal medical peer review medical management audit (May 2012). o These monitoring/audit tools included indicators to allow the Facility to determine compliance with the Settlement Agreement in important areas of medical care. However, the audit tools needed to reflect monitoring of all aspects of medical care (i.e., preventive, routine care, quality of assessments, acute care, and post hospital care). The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews. o For these audit tools, the Self-Assessment identified many of the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). However, the Self-Assessment did not identify the sample of records audited as part of the internal and external reviews. o However, based on the Monitoring Team's review of the actual internal and external audits, these sample size(s) were not adequate to consider them representative samples for the medical management audits. For instance, two records were chosen for each of three diagnoses (i.e., diabetes, constipation, and seizures). Although that represented an adequate sample size for review of diabetes (three of 14), it did not represent an adequate sample size for the diagnoses with a large applicable population, such as constipation

	(three of 141). o The monitoring/audit tools had some instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, this process remained an ongoing endeavor to improve the audit questions and the interpretation of findings. o The following staff/positions were responsible for completing the audit tools: PCPs from other facilities for the external peer review, and the PCPs at LBSSLC for the internal peer review. o The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). o For improved inter-rater reliability across the state, the State Office had brought on two physicians to complete these external audits at all sites. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. Databases included: tracking of annual medical assessments and quarterly medical reviews; tracking databases for DEXA scans, mammograms, colonoscopies; closure tracking of provider morning meetings; and ISPA tracking database. ▪ The quality of the data maintained in the databases was noted to be complete and accurate in some areas of preventive care (e.g., osteoporosis, colonoscopies, and mammograms). However, the quarterly medical reviews database might be incomplete, because the Monitoring Team's record review indicated increased compliance compared to the database information. Examples of databases/data sources that were not considered included: data related to the adequacy of pap smear monitoring, the quality of the content of the annual medical assessments (e.g., family history, active problem list completion, transition information, documenting communication to the ER in preparation for transfer of an individual, documentation of audiological assessments on the preventive flow sheet, etc.), and the quality of the quarterly medical reviews (e.g., completeness of information concerning ER visits and hospitalizations, the variation in documenting weights and weight loss/gain, etc.). However, on a positive note, in an effort to expand its self-assessment activities, the Medical Department had created additional clinical indicators, and database development recently had been completed. The Monitoring Team looks forward to the inclusion of this information in future Self-Assessments. ▪ The Facility presented data in a meaningful/useful way in a number of instances. However, concerns continued to be noted. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items, as noted above. o Did not distinguish data collected by the QA Department versus the program/discipline. However, it appeared all the data reviewed was based on findings of the Medical Department and not the QA Department. ▪ The Facility rated itself as being noncompliant with all subsections of Section L. This was consistent with the Monitoring Team's findings.

	▪ The Facility data identified areas in need of improvement. Although this information generally was not included in the Facility Self-Assessment and references were not made to corrective action plans or other documents that would describe such efforts, for some of the data analyzed, there were practical application steps that followed (e.g., dehydration training, review or reasons for ER visits and hospitalizations, etc.) This component should be expanded to other areas as data analysis is finalized (e.g., the next step in reducing the "unknown reason" for missed appointments, and administrative reasons for missed appointments). In addition, the Facility Self-Assessment should point the reader to documents that show what actions the Facility took to address problems identified.
	Summary of Monitor's Assessment: The Medical Department had made progress in a number of areas. The format of the provider morning meeting was a mature structure through which numerous aspects of medical care were discussed and processed in an efficient manner, and areas of concern identified, assignments made to either members of the meeting or to the IDTs, and closure of these tracked. Observation of these meetings and a review of the minutes over a several week period provided a level of confidence that closure was occurring for identified concerns. However, observation of the morning meetings indicated that critical review of potential steps to prevent recurrent hospitalizations or ER visits remained an area needing improvement. Open record reviews would assist in resolving this area of need. There has also been progress in a number of databases, such as osteoporosis, mammograms, and colonoscopies, necessary to ensure individuals received adequate preventative care. The Medical Department was in the early stages of determining an audit process and database for clinical indicators of diagnoses/ hospitalizations/ER visits that would be collected in addition to the external and internal peer review clinical indicators. However, some challenges remained. The Monitoring Team's record reviews indicated compliance with quarterly medical reviews was greater than the database indicated, suggesting information was not being returned to the medical administration for entry into the database. Tracking of PNMT recommendations through to PCP orders remained in the early stages of implementation. Determining the cause of missed appointments remained an area that needed an improved system of information retrieval. In addition, measurable clinical indicators should be created for all the aspects of care for Section L. It will be important to maintain the success that had occurred in creating monitoring systems, while efficiently adding monitoring components to identify areas that would benefit from improved quality.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive	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 the team process, routine care and preventative care, medical	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	management of acute and chronic conditions, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> For the census of 211 as of 10/1/12, there were four PCPs, including three physicians and one physician assistant responsible for this population. The Medical Director had a caseload of 15. Other PCPs had caseloads ranging from 63 to 68. There was no vacancy in the department. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated 8/24/12. Of the primary care providers in the department four out of four (100%) were current in CPR. Of the four PCPs in the Medical Department, a list of CME credits was submitted for four PCPs. This varied from one to 31 hours. The purpose of reviewing CME was to determine if the CME focused on diagnoses and topics that would enhance the practice patterns of the PCPs at the Facility. Conference titles/certificates were submitted. Titles included general internal medicine updates, risk management, family medicine updates, and side effects of antiepileptic drugs. These were core topics readily applicable to the care of individuals residing at LBSSLC. <u>Physician Participation In Team Process</u> For the three provider morning meetings observed, there was documentation of attendance in the minutes for two of three meetings. There was a signed attendance roster in three of three meetings, but the roster for 10/4/12 was misplaced and the morning minutes reflected this. For the three provider morning meetings observed and the minutes for two on adjacent days, there were four hospitalizations (i.e., Individual #250, Individual #191, Individual #33, and Individual #29), and four ER visits (i.e., Individual #12, Individual #22, Individual #154, and Individual #269). Based on the Monitoring Team's observations and review of documentation: ▪ For no cases of health status change were critical clinical questions raised followed by a request for the IDT to meet or review the case for preventive measures, and development of an ISPA. ▪ For two of four hospitalizations (i.e., Individual #250, Individual #191), critical clinical questions were raised/identified as needing closure among provider morning team members concerning steps to be taken to prevent a recurrence. ▪ For two of four hospitalizations (Individual #250, Individual #29), there was a request that the record be reviewed to determine preceding events, monitoring intensity, etc., before the onset of acute illness. ▪ The hospital nurse liaison reported an update with written report based on a	

#	Provision	Assessment of Status	Compliance
		visit the prior business day for one of one hospitalization during the monitoring observed meeting of 10/2/12, an update with written report for one of two hospitalizations during the 10/3/12 meeting, an update with written report for two of two hospitalizations during the 10/4/12 meeting, and an update with written report for one of one hospitalization during the 10/5/12 meeting. ▪ For one individual, there appeared to be a discrepancy in information recorded by the residential staff and the findings in the ER. There was no formal request for follow-up steps or assignment of review initiated by a clinical department to request an investigation of this discrepancy with closure back to the committee. For the three provider morning meetings observed, the on-call PCP (from the prior evening) contributed to discussion of the cases in three of three meetings. For one hospitalization at the three morning medical meetings observed, there was presentation of the results of a record review. Three ISPAs (i.e., for Individual #82, Individual #242, and Individual #139) were reviewed and accepted during the three morning medical meetings observed. Ten consults and diagnostic test results were reviewed during the three morning medical meetings observed. For the three morning medical meetings observed, nine assignments for further updates were identified (i.e., for Individual #220 - two closure concerns; others with one closure concern included: Individual #76, Individual #22, Individual #201, Individual #321 Individual #284, Individual #242, and Individual #321). For the three morning medical meetings observed, updated information was provided for closure for three individuals (i.e., Individual #220 for two closure concerns, Individual #22, and Individual #201). There was an additional closure on a clinical administrative concern (i.e., flu vaccine). For one individual, there were two incidents of psychiatric concerns. The discussion included updates by psychiatry and psychology. One closure concerned for one individual, an attempted ingestion of an inedible object was pica or other behavior, because there was not a history of pica. Discussion included information by psychology, psychiatry, the PCP, and the QDDP Educator. A third individual had a fall with injury with a history of a seizure and possibly orthostatic hypotension, and was sent to the ER. There was discussion about the best mode of transport to the ER, given the time involved, and the type of incident. Nursing and Medical department staff provided information. The case was closed, but also led to the need for an updated policy concerning transport to the ER.	

#	Provision	Assessment of Status	Compliance
		In summary, although review of minutes of provider morning minutes showed that when issues were identified, the provider morning team followed them until requested documentation was obtained (e.g., an ISPS), it remained unclear if the group reviewed the quality of the documentation to ensure adequate action had been taken by the IDT and/or member of the IDT to which the assignment was made. In addition, critical review of potential steps to prevent recurrent hospitalizations or ER visits remained an area needing improvement. Open record reviews would assist in resolving this area of need. Additional detailed discussion of provider morning meetings is provided with regard to Section G.1. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. Although the dates over the entire year were requested for all individuals, information was provided for annuals completed from 1/1/11 through 8/21/12 for 113 individuals. This allowed comparison of timeliness of completion to the prior annual medical assessment and physical exam. Individuals newly admitted within the prior six months were omitted. For 16 individuals, the data entry was problematic, and the dates of completion could not be determined or were not reliable. This provided a basis of 97 (i.e., 113 less 16) individuals for whom data was complete. Of these, 83 out of 97 (86%) of the annual medical assessments were completed within 365 days of the prior assessment. For 21 individuals, 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. For the 21 individuals, compliance was 17 out of 21 (81%). For the 21 most recent annual medical assessments: ▪ There was an interval history included as part of the document in 21 of 21 reviews (100%). ▪ The major active problems listed had plans of care addressing each of the major diagnoses in 21 of 21 assessments (100%). ▪ All 21 of 21 (100%) addressed smoking history. ▪ Family history was recorded in nine out of 21 (43%), but was considered adequate/helpful in two out of 21 (10%). ▪ A discussion of individual's appropriateness for transition to the community was included in 21 of 21 (100%). Statements indicated whether supports in the community could be provided for the individual, and whether or not the individual could be served in a less restrictive environment. However, it was	

#	Provision	Assessment of Status	Compliance
		unclear whether or not PCPs had a clear understanding of the supports available in community settings. Additional education likely would be helpful. Information was submitted concerning completion of quarterly medical reviews. The timeframe used was a 90-day interval, and a quarterly review was considered timely if it was completed between seven days before the 90 days through 13 days after the 90 days (similar to a Pharmacy Department's quarterly review requirement). This is to allow the time periods for the quarterlies to remain consistent from year to year, which allows the annual assessment to be completed each year at approximately the same time at least 10 days prior to the ISP. Without allowance of a short time period on either side of the 90 day due date, the annual would temporally drift further from the ISP date as the years advanced. It is understood that this interpretation might be more or less restrictive than federal or state regulatory requirements. Compliance for this report is not intended to imply compliance with requirements of other regulatory bodies. A list of 152 individuals was submitted for which the prior two quarterlies were reported, if available. One individual was removed from the list of 152, because the individual was a new admission, and quarterlies would not have occurred at the time of the report generation. Given that the census of 9/14/12 was 214, the discrepancy in number of individuals listed was not stated. For a census of 214, for an entire year, there would be expected to be three quarterlies and one annual. The Facility should be able to provide evidence of 642 quarterlies over a year, or 321 quarterlies for the half year. Information submitted indicated that 139 quarterlies were completed (139/321=43%). However, 23 of these fell outside the range of timeliness, leaving 116 that were completed in a timely manner, which was 116out of 321, or a 36% completion rate. It was noted that for each building, the entire population had the quarterly completed on the same date. As part of the monitoring review process, the Monitoring Team selected the medical records of six individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on different sampling methods. Every 35th name listed on a census was selected, after the first name was chosen by random selection. A second sample of six was selected by identifying individuals with various specific diagnoses/health care issues, and selecting a sample of individuals from each category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This additional sample was selected to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. For this sample of 12 individuals, documents reviewed included the preventive care flow	

#	Provision	Assessment of Status	Compliance
		sheet; physician orders for the past one year; integrated progress notes for the past one year; most recent BSP; last annual ISP and subsequent addendums; labs, x-rays, and consult forms for the past one 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 any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From 12 active medical records reviewed: ▪ 12 of 12 (100%) annual medical assessments had been completed in a timely manner. ▪ Active problem lists appeared to be thorough in eight of 12 (67%). ▪ 12 (100%) had information about smoking history. ▪ A family history was documented (or attempts at obtaining this information) in three of 12 (25%) records. ▪ 10 of 12 (83%) had information discussing appropriateness for transition to the community. ▪ The DG-1 forms were reviewed. Of the 12 DG-1s reviewed, nine (75%) had updated diagnoses. These 12 medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In 12 (100%), the SOAP format was used, and included date and time on the IPN. The 12 medical records (100%) had a PCP quarterly review of medical progress during any quarter in 2012. Eleven of the 12 (92%) medical records had a current quarterly medical review (from July 2012 onward). Eight of 12 (67%) had three medical quarterly reviews for 2012. Two of 12 had two quarterly medical reviews in which the annual did not replace a quarterly review. The Medical Department did not appear to utilize the annual exam as a replacement for a quarterly. Information indicated that for 12 medical records, three quarterlies would then be expected, or a total of 36 records. During this time period, 28 out of 36 (78%) were submitted. The database previously discussed indicated a 36% compliance rate. The difference might be due to the selection of more individuals with complex needs located in one home in which quarterlies were up-to-date. It also might reflect a lack of reporting to medical administration when the form is completed. Contents of the quarterly medical reviews were reviewed for completeness. A template had been created that allowed PCPs to complete components consistently. These included such aspects of clinical care as listing allergies, chronic conditions, ER visits, hospitalizations, consultations, and procedures. Neurological, gastrointestinal,	

#	Provision	Assessment of Status	Compliance
		respiratory, and Genitourinary/gynecologic organ systems had brief "yes/no" questions to be updated. At the bottom of the one-page document was an area for plans, followed by signature, and date of the PCP. This was not filed under the IPN section of the record, but in a separate section of the active record. Based on the sample of records reviewed: ▪ Major diagnoses were listed in 36 of 36 medical quarterly reviews completed in 2012. ▪ A weight was recorded in all 36, but there was usually no indication of when it was measured. Usually a change in weight was recorded, but for the majority, there was no indication of the date of the prior weight used in comparing values (e.g., last month, last quarter, etc.). ▪ There were brief comments/entries listing numbers of seizures (if applicable) in 19 of 19 medical quarterly reviews. ▪ There was documentation of new medication orders in 13 of 36 medical quarterly reviews. ▪ Important/abnormal labs and drug levels were documented in six of 36 medical quarterly reviews. ▪ There was documentation of ER visits, and hospitalizations with dates and discharge diagnoses/treatments in eight of 36 medical quarterly reviews. It was noted that of the 36, there were two hospitalizations/ER visits that were not recorded in the quarterly medical reviews. ▪ There was documentation of important consultation results (brief) in 20 of 36 medical quarterly reviews. <u>Access to Specialists</u> The following numbers of offsite visits for consultation or procedures were documented: ▪ Specialty Diagnostic tests: Covenant Lake/Women and Children's Hospital, University Medical Center, Grace Medical Center: 54 completed, 31 not completed; ▪ Allergy/Asthma: three completed, two not completed; ▪ Audiology: one completed, none not completed; ▪ Cardiology: 21 completed, seven not completed; ▪ Dermatology: 12 completed, none not completed; ▪ Ear Nose Throat (ENT): 12 completed, two not completed; ▪ Community Internist/ Family Physician: four completed, two not completed; ▪ Gastroenterology: 67 completed, 25 not completed; ▪ General surgery: two completed, none not completed; ▪ Gynecology: two completed, one not completed; ▪ Head injury specialist: none completed, one not completed; ▪ Hematology: 13 completed, five not completed;	

#	Provision	Assessment of Status	Compliance
		▪ Infection Clinic: one completed, none not completed; ▪ Internal medicine: one completed, one not completed; ▪ Nephrology: six completed, six not completed; ▪ Neurology: 23 completed, nine not completed; ▪ Neurosurgery: two completed, none not completed; ▪ Oncology: eight completed, none not completed; ▪ Ophthalmology: 18 completed, five not completed; ▪ Orthopedics/orthopedic surgery: nine completed, one not completed; ▪ Podiatry: two completed, two not completed; ▪ Preventive screening (includes mammograms and DEXA scans): 65 completed, 61 not completed; ▪ Pulmonology: 16 completed, nine not completed; ▪ Radiology: 37 completed, 17 not completed; ▪ Rheumatology: one completed, one not completed; ▪ Sleep Studies: eight completed, four not completed; ▪ Pedorthics: six completed, none not completed; ▪ Surgery: 12 completed, two not completed; ▪ Urology: 25 completed, seven not completed; ▪ Vascular surgery: one completed, none not completed; and ▪ Wound Clinic/Specialist: eight completed, four not completed. From an assessment of the information provided, there were 689 scheduled appointments, of which 440 (64%) were completed. The information provided for offsite consultation appeared incomplete and confusing. Several entries had no information under "report comments" regarding whether the appointment had been completed or not. It is recommended that a separate column be added to record whether the visit was completed. In addition, at times, it was not clear whether the information provided under "report comments" meant the appointment was rescheduled/cancelled, or the follow-up appointment was cancelled or rescheduled. Additionally, it was not helpful to have the visits sorted by hospital. The information is required for discipline-specific visits, and it would have been helpful to add *esophagogastroduodenoscopies* (EGDs) and colonoscopies under the gastrointestinal (GI) section than to sort it according to the Facility in which it was done. Overall, the database appeared to be confusing in its presentation, and the structural components needed to be reviewed. Based on these concerns, it is recommended that the Medical Department develop a report with focus on specialty appointment (rather than location of appointment or test, and rather than name of individual specialists which might not be further identified by specialty). It would be helpful to list appointments per specialty to determine referral patterns to specialties. The report should also summarize the number of appointments, number of completed appointments, reasons for missed appointments,	

#	Provision	Assessment of Status	Compliance
		and follow-up of missed appointments to determine when the individuals successfully completed the specialty visit. From separate documentation, with dates of 2/28/12 though 9/7/12, it was determined that 155 offsite consultation appointments were missed. Of these, 26 (17%) were due to refusals and behaviors. Other reasons for missed appointments included: incomplete paperwork - 26 (17%), consultant cancelling appointment for various reasons - 39 (25%), various administrative reasons - 37 (24%), poor communication – seven, guardian refusal for consent - seven, lack of transportation – four, and scheduling conflict – six. It was noted that appointments missed per individual ranged from one to nine. Separately, it was determined that there were 35 offsite neurology appointments. Of these 25 were completed, for a completion rate of 71%. The Medical Department submitted documentation of missed/cancelled appointments from 4/1/12 to 9/1/12. Results indicated that 13.3% were due to paperwork and consent issues, 29.7% were cancelled by the consultant's office, 3% were rescheduled due to being on a state holiday, 10.2% were due to poor communication (e.g., individual did not maintain nothing by mouth status, pre-sedation not given, etc.), 4% were due to transportation issues, 0.08% were due to unavailability of preferred staff, 21% had behaviors/refusals, 4% were due to guardian refusal, 7% were due to having another appointment scheduled, 0.08% were on a community tour, and 1.6% had been hospitalized at time of appointment. On site, several specialty clinics were held to meet the needs of the individuals since January 2012. These included the following specialty clinics with scheduled dates: ▪ Endocrinology Clinic - 1/31/12, 2/29/12, 3/29/12, 5/31/12, 7/5/12, and 8/23/12; ▪ Gynecology Clinic – 4/18/12, and 8/1/12; ▪ Neurology Clinic – 1/11/12, 1/25/12, 1/27/12, 2/17/12, 2/22/12, 3/7/12, 3/21/12, 3/23/12, 4/4/12, 5/9/12, 5/11/12, 5/23/12, 6/6/12, 6/20/12, 6/22/12, 7/11/12, 7/13/12, 7/25/12, 8/15/12, and 8/24/12; ▪ Podiatry Clinic – 1/25/12, 2/22/12, 5/23/12, 6/20/12, 7/18/12, and 8/22/12; and ▪ Vision Clinic – 2/3/12, 2/24/12, 4/6/12, 5/4/12, 7/6/12, 8/3/12, and 8/17/12. From a database covering the period from 2/3/12 through 8/29/12, 141 onsite appointments were missed. Of the appointments missed, 25 were due to refusals (18%). Other reasons for missed appointments included: scheduling conflict – eight, medical illness – eight, behaviors – two, and unknown – 95. The unknown category of reason for	

#	Provision	Assessment of Status	Compliance
		the missed appointment was the greatest percentage of all reasons, at 67%. The Medical Department is encouraged to determine the causes of missed appointments, and based on findings, begin to reduce the number of missed appointments. Information was submitted that 22 of the 141 (16%) had subsequently completed an appointment, the record was reviewed and the individual was discharged from the specialty clinic, or it was determined that the individual needed to be seen on an as needed (pro re nata or "PRN") basis only. The Facility also indicated it began to track missed appointments of onsite clinics as of May 2012. A separate listing of absentee clinic visits was recorded in the 5/8/12 provider meeting minutes. The following number of missed appointments per month were listed: January 2012 - 64, February 2012 – 84, March 2012 – 40, and April 2012 - 40. To assist the Medical and Dental Departments in documenting the reason for a missed appointment due to the individual refusing or having behaviors, an in-service was provided to each home for the direct support professionals, assistant home team leaders, and home team leaders. The in-service provided guidance concerning steps to be taken. To reduce the number of recurrent missed appointments in the onsite specialty clinics, the RN Clinic Manager communicated via email to the IDTs of individuals with missed appointments to ensure the IDT was aware of the missed appointment. A sample of the tracking was provided for the missed appointments for the vision clinic of 8/3/12, and the neurology clinic of 6/20/12. Reason for the missed appointment, home address, and reason provided for the missed appointment was recorded, when known. There was a column for resolution/closure that was not completed for the vision clinic of 8/3/12, but was completed for the neurology clinic of 6/20/12. The Medical Department indicated this information was communicated to the IDTs for resolution. Separately, more recent updated information was provided for the onsite clinics, including the date of the clinic, the number of appointments completed, the number of appointments not completed, and the action plan. The following summarizes this information: ▪ For the Vision Clinic, dates of clinics included 5/22/12 (not reported in the prior list of dates for this clinic), 6/14/12 (not reported in the prior list of dates for this clinic), 7/6/12, 8/3/12, 8/17/12, and more recent clinics of 9/7/12, and 9/14/12. A total of 170 appointments were scheduled, of which 135 were kept (79%). During this time period 10 individuals were listed that were scheduled for one or more appointments, and did not complete the visit. All 10 continued to be rescheduled. ▪ Gynecology Clinics were scheduled for 4/18/12 and 8/1/12. For these two clinics, 30 appointments were scheduled, and 26 were completed (87%). One	

#	Provision	Assessment of Status	Compliance
		individual had an appointment with both clinics and did not complete an appointment. ▪ Podiatry clinic appointments were submitted for 5/23/12, 6/20/12, and a more recent clinic held on 9/19/12. Of note, the prior list of podiatry clinics included 7/18/12 and 8/22/12, but these were not submitted with this more current information. It could not be determined if these two clinics were completed. For the three clinics identified, there were 44 appointments, and 32 appointments completed (73%). For nine individuals, appointments had not been completed, but were rescheduled. ▪ Endocrinology clinics were scheduled for 5/31/12, 7/5/12, 8/23/12, and more recently, 9/27/12. A total of 92 appointments were scheduled, and 69 appointments were completed (75%). For 13 individuals that missed appointments, the specialist completed a record review. For seven individuals, a follow-up appointment was successfully completed. ▪ Updated information indicated Neurology clinics occurred on 6/6/12, 6/20/12, 7/11/12, 7/25/12, 8/15/12, and more recently on 8/29/12, and 9/16/12. The list previously quoted included neurology clinics on 6/22/12, 7/13/12, and 8/24/12. The reason for the discrepancy was not indicated. For these seven clinic dates, there were 101 appointments scheduled, and 88 appointments completed (87%). Of the 13 individuals that missed appointments, six subsequently completed an appointment. Five had record reviews completed, one was rescheduled into October 2012, and one had a record review with follow up neurology appointment, but information was not provided to confirm the appointment was completed. Separately, it was determined that from January through August 2012, there were a total of 267 neurology appointments. Information was available for missed appointments from the 6/6/12 neurology clinic forward. From 6/6/12 through August, there were 109 neurology appointments. Of these, 95 (87%) were kept. Although it was positive that efforts were made to reschedule missed appointments, work was still needed to determine the underlying causes of the missed appointments, and address them to the extent possible. Such efforts might entail working with individuals' teams in relation to refusals, and/or putting other mechanisms in place to ensure appointments are kept. With regard to sedation prior to procedures, for five individuals, information was submitted concerning the use of a sedative medication prior to the procedure, to improve cooperation and compliance. ▪ Four of five were given by mouth (PO) medication. One of five was given intramuscular (IM) medication.	

#	Provision	Assessment of Status	Compliance
		▪ There was agreement across forms for the procedure being performed in four of five. For one, the restraint checklist form indicated DEXA, but the consent and HRC approval was for a CT scan of the head. ▪ Five of five used the medical/dental restraint checklist form. ▪ Five of five were monitored prior to the procedure while still in the home, as well as after return from the procedure. ▪ Five of five had consent for the procedure. ▪ Five of five had HRC approval for the sedation. ▪ None of five completed the procedure/test and all had to be rescheduled. Each individual remained unable to cooperate with the procedure. The Medical Department indicated that there were 25 to 26 desensitization plans for medical visits, of which less than five had been implemented. The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail in Section L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in 12 out of 12 records reviewed (100%). Preventive care flow sheets were up-to-date in four out of 12 records reviewed (33%). Current vision screening was documented in 11 out of 12 of the records reviewed (92%). Periodic audiological screening was recommended for 11 of the individuals reviewed. Of these, documents were submitted indicated a current screening in nine of 11 records reviewed (82%). With regard to immunizations: ▪ The influenza vaccination had been given to 12 individuals (100%) in a timely manner during 2011. ▪ 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 12 of the 12 active records reviewed (100%). ▪ Whether the individual needed to receive a hepatitis B vaccine (depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or was being tracked for completion), was recorded in 11 of the 12 active records reviewed (92%).	

#	Provision	Assessment of Status	Compliance
		A list was submitted indicating women residing at LBSSLC who were 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 46 women were identified as being over the age of 40. Of these, there were four women aged 70 or greater. The DADS SSLC Preventive Health Care Guidelines - SSLCs August 30, 2011 policy was to be followed. Of these 42 women age 40 to 70, eight had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 34 women, 29 had mammograms or a clinically appropriate alternative within the prior year. This was a compliance rate of 29 out of 34 (85%). Of the four women aged 70 or greater, one had reasons for not completing a mammogram. Of the three remaining women, three had a mammogram completed during either 2011 or 2012. From the sample of 12 medical records reviews, there were three females between the ages of 40 and 70. Of these, one of three (33%) was up-to-date on mammogram testing. From the sample of 12 active records reviewed, four of four females (100%) for whom pap smears were indicated completed this test within the prior three years. Additionally, there was one female in this age range that did not meet criteria/have risk factors that necessitated testing in the prior three years. A list was submitted identifying women residing at LBSSLC who were between the ages of 40 and 70. Although the numbers were not identical to the list of women referenced for a review of mammography completion, the total number of women was similar. A list of 45 women was submitted, of which one was identified as being over the age of 70. Of these 44 women in this age range, six had reasons for not completing a pap smear. A total of 38 were then eligible for preventive testing with pap smears. All 38 had a documented pap smear listed. The dates of the last pap smear indicated 27 out of 38 occurred in the prior three years. There were two in which the gynecologist indicated that pap smears at less frequent intervals were adequate, or pap smears were no longer indicated. The women for whom a pap smear had been completed in the prior three years or rationale was provided totaled 29 out of 38 (76%). There remained nine women for whom the last pap smear was greater than three years prior, and for which no reason was provided. Additionally, no information was provided indicating whether an individual met guidelines for more frequent pap smear monitoring (due to a prior abnormal pap, etc.). Reasons for hysterectomy were not provided. It is recommended that the Facility track the timely completion of pap smears in the eligible population, including whether prior pap smears were normal and justified three year (or more) interval testing schedules, as well as recording whether hysterectomies were due to non-malignancies.	

#	Provision	Assessment of Status	Compliance
		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 84 names was submitted. Of these, six had reasons not to order a colonoscopy. One was over the age of 75. Therefore, the eligible population was 77 individuals. Of these, there was sufficient data to indicate that 66 (86%) completed a colonoscopy within the prior 10 years, had alternate testing considered acceptable as clinical equivalents, or had alternative gastroenterology recommendations that were being followed. For three of the 11 for which a colonoscopy had not been completed by the time of the submitted documentation, there was a procedure pending for three individuals. For five individuals, the information provided was unclear, and a determination of whether a colonoscopy or other acceptable alternative had been completed could not be determined. The 12 medical records were reviewed to determine timeliness of colonoscopies in the eligible population. There were six individuals age 50 to 75. There was documentation that five of six (83%) had a completed or attempted colonoscopy documented within the prior 10 years. The Facility submitted information based on the request for "ISPAs addressing missed appointments or refusals for the past three months for mammograms and colonoscopies." There were seven ISPAs and one ISP/IRRF submitted. Two focused on colonoscopy refusals and one focused on inability to obtain a mammogram. The others were not related to the request (e.g., refusal to complete DEXA, refusal to complete podiatry clinic, and refusal to complete allergy clinic). Of the three, two had additional steps to be taken by the IDT and showed critical thinking and decision-making in resolving the challenge of refusal/missed appointment. For one, although there was an added step, it did not appear to address the problem of refusal. It was not known if these three represented all the ISPAs addressing missed appointments/refusals in the past three months for mammograms and colonoscopies, or if this was a sample. 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, along with other comorbid conditions that may be associated with increased fracture risk, treatment would be ordered to optimally treat the individual. A total of 123 individuals with a diagnosis of osteopenia or osteoporosis were reviewed.	

#	Provision	Assessment of Status	Compliance
		Of these, 112 had a DEXA scan submitted. Of the 112 individuals reviewed, based on T scores, 63 had osteoporosis and 49 had osteopenia. Information was not provided to determine which of the individuals on the list had osteoporosis and which had osteopenia. It is recommended that future databases clearly identify which individuals were diagnosed with osteopenia and which were diagnosed with osteoporosis. The Facility might have been considered other factors according to literature guidelines, but this information not available for this review, and the T score was used as a guide to differentiate osteopenia from osteoporosis. The listing included current medications and dosages, and included use of Calcium and Vitamin D supplementation, as well as a calculation of average intake of Calcium and Vitamin D through the individual's diet or enteral feeding. For those with osteoporosis based on T scores, 60 out of 63 (95%) were prescribed a bisphosphonate, Miacalcin, or Prolia. More specifically, 38 out of 63 (60%) were prescribed a bisphosphonate, 14 out of 63 (22%) were prescribed Miacalcin, and five out of 63 (8%) were prescribed Prolia. Three out of 63 (5%) were prescribed a combination of these medications. A total of 58 out of 63 (92%) were prescribed Calcium supplementation, and 62 out of 63 (98%) were prescribed Vitamin D supplementation. For those with osteopenia based on T scores, 38 out of 49 (78%) were prescribed a medication to treat or prevent osteoporosis. It was noted that 11 of the 38 were prescribed treatment dosage strength for osteoporosis (for two individuals a combination of a bisphosphonate or Prolia and Miacalcin were prescribed) rather than a dosage strength recommended for the prevention of osteoporosis in those with osteopenia. The rationale for use of Miacalcin (prescribed for seven individuals) was also not clear, and suggested other risk factors might have been considered. For those with osteopenia, 43 out of 49 (88%) were prescribed Calcium supplementation, and 38 out of 49 (78%) were prescribed Vitamin D supplementation. It is recommended that for those individuals with a T score less than -1.0 and greater than -2.5, the drug regimen and risk profile for development of osteoporosis be reviewed to ensure appropriate/optimal dosage of these various classes of medication. From the sample of 12 medical records reviewed, nine of 12 (75%) had a diagnosis of osteoporosis or osteopenia. ▪ Of these nine, eight (89%) had a DEXA scan/T score recorded. ▪ Of these eight, eight (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these nine, seven (78%) had been prescribed supplemental calcium and vitamin D. ▪ Of these nine, nine (100%) had a bisphosphonate, Miacalcin or alternative medication prescribed for treatment of osteoporosis or osteopenia.	

#	Provision	Assessment of Status	Compliance
		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. Five of five (100%) had a current thyroid test completed in 2012. <u>Acute and Emergency Care</u> *Emergency Room Visits* The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These individuals are listed in the documents reviewed section. Ten of the 10 had gone to the ER from their residence. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified verbally of the transport of the individual with appropriate medical background information for five of 10 (50%) records. ▪ Prior to the transfer to the ER, a PCP was on site for three of these transfers. In two of three (67%) records, the PCP had written an IPN that included the date and time. ▪ For none of two IPN entries by PCPs (0%), vital signs were recorded. ▪ For two of two IPN entries by PCPs (100%), reason for the transfer was documented. ▪ In two of two IPN entries by PCPs (100%), the SOAP format was utilized. ▪ A copy of the ER report that was filed in the record was submitted in 10 of 10 (100%). ▪ Of the 10 ER visits, diagnostic categories included: respiratory – one, neurological – three, feeding tube complications - two, trauma – three, and Genitourinary – one. ▪ When the individual returned to the Facility after evaluation at the ER, nine of the 10 active records (90%) had an IPN. Of these nine, eight (89%) utilized a SOAP format. ▪ These notes included the date and time in nine of nine (100%). ▪ Vital signs were recorded in four of nine (44%) of these IPNs. ▪ A summary of ER information and findings was included in nine of nine IPN notes (100%). ▪ Three of the nine records (33%) had additional PCP notes as follow-up to the original post emergency room IPN. Additionally, there were three PNMT notes, two psychiatry notes, and one neurology note submitted as follow-up to the ER visits. ▪ For 10 of 10 (100%), treatment of the emergency condition was considered timely. There were no perceived delays in care in transferring the individuals to the ER.	

#	Provision	Assessment of Status	Compliance
		Hospitalizations Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review: ▪ A PCP was on site during the transfer for six of 10 (60%) cases. For these six records, the PCP wrote a pre-hospital evaluation/transfer note in six (100%) of the hospitalizations. For four of these, the transfer occurred after hours or on weekends. ▪ Ten individuals returned to the Facility. None died while in the hospital, and none were transferred to a rehabilitation or long-term acute care setting. Of the 10 individuals that returned to the Facility, 10 (100%) had IPNs post hospitalization. ▪ Of the 10 post-hospital IPNs submitted, nine of nine applicable IPNs (100%) included vital signs. One note was written from verbal information shared between hospital and SSLC physicians, and the individual was en-route. As a result, vital signs and objective evaluation could not be assessed. ▪ 10 of 10 (100%) included date, time. ▪ 10 of 10 (100%) had an adequate summary of hospital events and findings. ▪ Although 10 of 10 (100%) active records used the SOAP format, one was based on verbal communication while the individual was en-route. Nine of nine applicable cases had completed SOAP (100%). ▪ Seven records of the hospitalized individuals (70%) included a copy of the hospital admission history and physical. ▪ Six of the 10 (60%) included a copy of the hospital discharge summary. ▪ Nine of 10 (90%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ Eight of the 10 (80%) included hospital liaison nurse notes for the individuals. For two individuals, the admission was either overnight or was over a weekend, and the hospital liaison nurse might not have had the opportunity to visit the individual in the hospital. ▪ For six of the 10 individuals that returned to the Facility (60%), an ISPA follow-up was submitted. ▪ Of the 10 hospitalizations, reasons given included: respiratory causes – four, pharmacological complications – one, neurological – two, sepsis – one, chest pain – one, and dehydration – one. LBSSLC did not have an infirmary. However, for those individuals needing increased nursing care on a temporary basis, one area of one of the residences was designated to receive these individuals (504 E Mesquite). From 8/1/11 through 8/31/12, four individuals were temporarily admitted to this residence. The diagnoses included UTI, vomiting, and dehydration. The length of stay varied from three to 36 days.	

#	Provision	Assessment of Status	Compliance
		For the 12 individuals for whom the medical records were reviewed, four of 12 (33%) were hospitalized one to three times in 2012. Four of 12 (33%) were hospitalized one to two times in 2011. Five of 12 (42%) individuals visited the ER in 2012. Three of 12 (25%) individuals visited the ER in 2011. *Pneumonia* There were four datasets that compiled incidents of pneumonia. LBSSLC did not have Avatar Tracking Pneumonia Forms. They did submit a report entitled "Pneumonia Profile Report," dated from February 28, 2012 through August 28, 2012. There were 18 pneumonias listed. However, two appeared to be the same pneumonia. It is recommended that the Medical Department review the data to ensure duplicate information is not included to ensure accuracy of information. From a document entitled "LbSSLC Infection Type by Month Report," dated 9/1/11 to 7/31/12, data from February through July (six months) was reviewed. This was in table format and listed five aspiration pneumonias and 16 healthcare acquired pneumonias. In similar format, a document was submitted entitled: "LBSSLC infection by month, home, person report" for July 2012. There was one aspiration pneumonia and three health care acquired pneumonias from two homes. In attempts to compare information in this report to "Pneumonia Profile Report," the February data was removed from this set, and the February and August data were removed from the "Pneumonia Profile Report, as well as two pneumonias which appeared to be reported twice. This left 13 pneumonias that occurred from March 1, 2012 through July 31, 2012 for the first data set and 14 for the second dataset. The discrepancy in the reporting of one pneumonia could not be reconciled further from the submitted data. However, the data agreement generally indicated reliability of information. From a set of data (untitled), for the time period of the past six months (reference date not provided), the type of diet/feeding route was provided, as well as the date of the last swallow study, if completed. This data indicated that 14 individuals had pneumonias during this six-month time period. ▪ Nine of these individuals were nothing by mouth (NPO) status, and nutrition was provided through a feeding tube. ▪ Five individuals had specialized diets (i.e., specific textured solids and specific thickened liquids). All five had had a swallow study. Four of these swallow studies were in the past two years. For one individual, the last swallow study was in 2006. A fourth data set was submitted as "Absolute numbers of new cases (prior year, prior month) for the following: pneumonia." To compare to the above three data sets, information from March 1 through July 31 was reviewed. During this time, according to	

#	Provision	Assessment of Status	Compliance
		this fourth dataset, there were 14 pneumonias. For August 2012, there were two additional pneumonias, which was consistent with the first dataset. For February 2012, this fourth dataset listed seven pneumonias, which was in agreement with the second dataset, which also provided information for February 2012. Additional information was also provided for sepsis. There were five individuals determined by the Facility to have had sepsis in the past year. There were four deaths for which sepsis had been determined to be the cause. It was noted that of the three deaths in the prior six months, none were from sepsis. One of three that died in the prior six months had been hospitalized in the prior year for sepsis. It is recommended that for those individuals diagnosed with sepsis, that there be an open chart review prior to their return to determine any early warning signs and symptoms of health status change that might reflect impending sepsis and the need for heightened medical monitoring. *Trauma* Since the last on site Monitoring Team visit, there were 15 individuals that went to the ER or were hospitalized for injuries. <u>Chronic Conditions and Specific Diagnostic Categories</u> As part of the review of 12 medical records, GERD was reviewed. Of the 12, five were diagnosed with GERD. Of these five, five had appropriate treatment (100%). Five were prescribed medications, two had a feeding tube placed in the past, and one had a procedure performed in 2012. The Facility listed five individuals with tracheostomies. 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. One individual was newly diagnosed with cardiovascular disease, and no cases of a newly diagnosed cancer were reported in the past year. An updated and complete list of pica or ingestion of inedible objects were submitted, entitled "Individuals that ingest inedible items," dated 8/17/12. All individuals with a diagnosis of pica or with a history of ingesting inedible items were listed. This totaled 36 individuals. The list did not include the number of events per individual. From January 1, 2012 to the date of the report, 8/17/12, there were nine individuals that had a pica incident. For the most recent six-month period form 2/17/12 to 8/17/12, there were three individuals listed as having pica incidents. A separate list (from TX-LB-1210-VI.4a) indicated that from January 1, 2012 through August 31, 2012, there were five individuals that had a pica incident. Since March 1,	

#	Provision	Assessment of Status	Compliance
		2012, through August 31, 2012, two pica incidents were recorded. Although there was some variation in time periods between the two, the difference in the number of pica incidents since January 1, 2012, indicated remaining discrepancies in the database. A total of 141 individuals had a diagnosis of constipation or were receiving anti-constipation medication at least weekly. According to data submitted, in April 2012, one individual required admission to the hospital for treatment of bowel obstruction or bowel perforation/complication. According to a separate file of data submitted entitled "Absolute numbers of new cases (prior year, prior month) for the following: bowel obstruction," except for the one bowel obstruction recorded in April 2012, there were no other months in which a bowel obstruction was recorded. *Skin Integrity* On April 13, 2012, the Skin Integrity Committee met and minutes were submitted. In these meeting minutes, two individuals with ongoing active pressure sores were documented. For a third individual, a prior pressure sore had healed. One of two active pressure sores developed at LBSSLC. One of these ulcers was noted to begin in the hospital or other setting. The minutes did not clearly state the number of ulcers present for one individual. One individual had two pressure ulcers. The minutes did not indicate the stage of the ulcers. A submitted document entitled "Absolute number of new cases (by month) of decubiti: fiscal year 2012," provided the following information per month for the number of decubiti: February 2012 - zero, March 2012 – two, April 2012 – zero, May 2012 - zero, June 2012 – zero, July 2012 – one, and August 2012 – one. For the six months of March through August 2012, there were a total of four new decubiti. *Seizure Management* A list was submitted indicating that as of 8/21/12, approximately 143 individuals had a diagnosis of a seizure disorder. The Facility submitted information concerning antiepileptic medication usage. As of 8/21/12, 99 individuals were prescribed antiepileptic medication. (A separate document entitled "List of seizure medications per individual for diagnosis of seizure disorder dated 8/21/12, listed 100 individuals). From the information provided for 99 individuals, the following data was provided: ▪ Of these 99, 41 (41%) were prescribed one antiepileptic medication, 30 (30%) were prescribed two antiepileptic medications, 17 (17%) were prescribed three antiepileptic medications, six (6%) were prescribed four antiepileptic medications, and five (5%) were prescribed five antiepileptic medications. ▪ Five individuals were considered to have a refractory seizure disorder. All five	

#	Provision	Assessment of Status	Compliance
		had a VNS implant, although two were not being utilized as of 8/21/12. ▪ In the prior six months, two individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. ▪ Additionally, 44 individuals with a diagnosis of seizures were on no antiepileptic medications. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 37 (37%) of individuals being treated for seizures were prescribed Dilantin, four (4%) were prescribed Primidone, 11 (11%) were prescribed Phenobarbital, and zero percent was prescribed Felbamate. Additionally, six individuals had a VNS implant. Of these, two were not being utilized as of 8/21/12. Five of the six with VNS implants had refractory seizures. 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 the most recent neurology consults submitted: ▪ Five of the five individuals (100%) had been seen more than once over the past year. ▪ For one of five individuals (20%), the notes indicated a description of the seizures. ▪ Three of five (60%) documented frequency/numbers of seizures since the last visit. ▪ Four of four (100%) included a review of current medications for seizures. It was noted that one individual was not prescribed anti-epileptic medication. ▪ One of four (25%) included a review of medication dosages. ▪ Three of four (75%) included recent blood levels of antiepileptic medications. ▪ Five of five (100%) included recommendations. ▪ For none of four individuals (0%), reference was made to the presence or not of side effects. ▪ For none of five individuals (0%), reference was made to wellness. Much of the above information would be expected to accompany the consult request as background information provided by the Facility staff (e.g., numbers of seizures, side effects tracking, etc.) and would not necessarily be required as part of the neurology consult note. It appeared other documents might have accompanied the consult request form, but there was little information available for analysis of this section other than the brief consultant entry from the information submitted. Since the Monitoring Team's last visit, there were no new policies or procedures for seizure management.	

#	Provision	Assessment of Status	Compliance
		Feeding Tubes To assist the PCPs in appropriate medication choice for those with jejunostomy tubes (J-tubes) and gastrostomy/jejunostomy Tubes (G/J tubes), the Pharmacy Department completed a review of medications that were not recommended for administration through a jejunostomy tube, as well as medications that might have altered (increased) absorption through a jejunostomy tube route. In the WORx software program, a warning was created for individuals with jejunostomy tubes to alert the pharmacist and PCP of this concern. The warning that appeared stated: "J tube: do not give quinolones, sucralfate, antacids or bismuth via j tube. Beta blockers, nitrates, opioids and tricyclic antidepressants have increased bioavailability when given by j tube." Additionally, a J-tube medication review was completed 9/29/12 and reviewed at the 10/2/12 P&T Committee. All individuals with J-tubes were reviewed. The study indicated that there were three individuals with J-tubes and one with a gastrojejunostomy tube. The gastrojejunostomy tube had two ports, one for the gastrostomy tube for medication administration and one through the jejunostomy tube for feeding formula. The review included such probes as whether "all drugs possible provided in liquid form," there was the "appropriate route for each medication on profile," and whether there was a "j tube precautions/contraindications reminder visible at pharmacy order entry screen." All three criteria were met. Additionally, medications contraindicated through a J-tube were studied. There were no individuals with J-tubes on antacids or bismuth compounds. There was an individual administered quinolones and Sucralfate (it appeared that both were given to one individual). However, this was the individual with a gastrojejunostomy tube and a double port for whom the gastrostomy port site was utilized for administration of the medication. For the drugs identified as having increased bioavailability due to lack of first pass metabolism, there were no individuals prescribed nitrates, opioids, or tricyclic antidepressants through a J-tube. There was one individual prescribed a beta-blocker, but this was a long-term medication, the individual had been prescribed this prior to J-tube placement, and there were no reported problems with the medication. The drug regimen review profiles submitted for these four individuals were dated 9/28/12. Background information was not available for these four individuals to determine if these individuals had PO abilities or were NPO, and it was not determined when a J-tube, or G-tube, or G/J tube was placed. The Monitoring Team's review provided results that differed in some areas compared to the Pharmacy Department's review. The following information was noted from the drug regimen review profiles that were submitted: ▪ Two of four (50%) had the warning for "j tube do not give quinolones, sucralfate, antacids, or bismuth via J tube. Beta blockers, nitrates opioids, and tricyclic	

#	Provision	Assessment of Status	Compliance
		antidepressants have increased bioavailability when given via j tube." One also mentioned "honey consistency order good as per 90 day orders" suggesting additional PO intake, although no recent medication had been prescribed orally. Two profile notes indicated: "medication crushed given by j tube in most upright position," bit did not mention the specific medications on the warning list. For one of these, there was an additional note concerning Sucralfate "must be administered via g tube only." ▪ Two of four had orders for oral medications in 2012. As these individuals had enteral feeding tubes, it was not clear the reason for the order for the oral route. ▪ Four of four had orders for G-tube administration of medication in 2012 as well as J-tube administration. It was not clear when a J-tube replaced a G-tube or G/ J tube in three of these. For one individual with a G/J tube with two ports, G-tube orders would be anticipated. For the other three individuals, there was insufficient information to determine the accuracy/rationale of orders of medication through a G-tube. ▪ Three of four had quinolone administration through a J-tube in 2012. The dates of administration were prior to the new warning system the pharmacy created, and the new warning system should assist in resolving this issue. ▪ One of four had hydrocodone administered through a J-tube in 2012. ▪ One of four was prescribed a beta-blocker through a J-tube in 2012. It is recommended that the medical staff review the route of orders for those with J-tubes and G/J tubes to ensure that the orders are consistent with the type of feeding tube present, consistent with the functional abilities of the individual, and consistent with the Pharmacy Department's recommendations for the individual and need for additional monitoring, etc. <u>Do Not Resuscitate Orders</u> A total of 11 individuals at the Facility had DNR orders in place. Ten were Resuscitation Status II and one was Resuscitation Status III. For 11 (100%), adequate clinical justification was provided for the DNR. Reasons provided for those with DNR orders included end stage renal disease (two), cancer (two), dementia (three), severe respiratory conditions (three), and severe multiple system disease (one). For 10 of the 11 individual for which a DNR order was in place, the "Resuscitative Status II" and "Resuscitative III" form was reviewed. For nine of 10, the Resuscitative forms were current. According to this document, the form "must be renewed at least annually; failure to renew or to designate alternate resuscitative status results in Resuscitative Status I designation." There was one individual for whom the form was overdue for an updated signature. A form for one individual was not submitted. Since the Monitoring Team last visit, on 8/20/12, there was one LBSSLC ethics	

#	Provision	Assessment of Status	Compliance
		committee meeting held, with discussion of one individual (i.e., Individual #281). The complicated medical course was reviewed. The individual was hospitalized at the time, and the hospital believed the individual was appropriate for palliative care with hospice services. An ethics committee meeting was called, and a member of the medical staff at the area hospital participated through a conference call. There appeared to be good collaboration between the hospital and LBSSLC, and thoughtful review of the complexities of this case. The decision was to make her a Resuscitation Status III (i.e., no resuscitative measures, palliative care only), because the risks of aggressive care were believed to outweigh treatment benefit. Committee minutes were available, as well as an attendance roster. Based on the State Office guidelines, it would have been helpful to summarize the lengthy meeting minutes into a succinct statement of the qualifying condition that met the State Office guidelines for the DNR status. This would be useful for any future reference in reviewing appropriateness of DNR status. It also was not clear where the meeting minutes would be filed, and whether they would be available to the IDT or not. From a review of 12 medical records, none of 12 (0%) had a DNR status. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Non-facility Physician Case Reviews</u> A revised document, dated 7/6/12, entitled "external and internal medical provider quality assurance audit" was submitted that provided clear guidance concerning the steps/tasks for successful completion of the process. Tasks for which detailed guidance was provided included: medical provider quality assurance audit database, determining "round," audit frequency, who conducts the audit, selection of the sample for review, conducting the initial audit, post-audit meetings, entering the initial audit responses and distribution of results, conducting the initial follow-up audit, entering the initial follow-up audit response, initial follow-up audit notifications, and additional follow-up notifications. A flow diagram also was submitted to illustrate this process. During the prior six months, the Facility completed one non-facility physician case review from August 21 to 22, 2012. The following represents a synopsis of the information: ▪ This external peer review included an external medical peer review audit and an external peer review medical management audit of clinical indicators for constipation, seizures, and UTIs. ▪ Although two external medical peer reviewers were scheduled to provide audits,	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
only one was able to complete the audit.
▪ For the one external medical peer review dated 8/22/12, a written report was completed. The author of this document was not identified. Information was summarized.
▪ PCP compliance in essential areas was provided in graph format.
▪ PCP compliance in non-essential areas was provided in graph format.
▪ A tabulation of corrective action plans per PCP was not provided.
▪ From this external medical provider review, areas that appeared to need improvement were documented and included: “Documentation was lacking in two of 12 charts to indicate why preventive services were not provided,” and “in the clinical guideline for constipation, one chart lacked documentation regarding the PCP documenting the effectiveness of treatment.”
▪ Areas that appeared to be strengths were documented and included: “There was appropriate documentation on the Active Problem List. Preventive Care was well documented. Labs, x-rays reports, and consultations were all signed and dated. A corresponding IPN was documented for findings, especially significantly abnormal results. Acute care issues and follow up care post-ER/Hospitalizations was appropriate and timely. Care was appropriate regarding the Clinical Guidelines.”
▪ The overall results of the thee most recent audits are presented in the table below:
<table>
<tr><th colspan="4">Peer Review General Medical Audits: % compliance</th></tr>
<tr><th>Round #</th><th>Dates of Review</th><th>Essential</th><th>Nonessential</th></tr>
<tr><td>#6 External & Internal</td><td>8/21/12 to 8/22/12</td><td>100%</td><td>98 to 100%</td></tr>
<tr><td>#5 Internal</td><td>May 2012</td><td>89-100%</td><td>85 to 94%</td></tr>
<tr><td>#5 External</td><td>February 2012</td><td>67-80%</td><td>77 to 94%</td></tr>
</table>
▪ The number of corrective action plans decreased over three peer review audits. The February 2012 external medical peer review documented 57 corrective action plans. The May 2012 internal medical peer review documented 41 corrective action plans. The August 2012 external and internal medical peer reviews documented 14 corrective action plans. The significant reduction in corrective actions indicated progress had occurred in the areas audited.
▪ The external review process did not appear to lead to a QA Department analysis of findings, including compliance rates as the average of all PCPs, compliance for each PCP, and trend analysis comparing this audit with results of prior audits to determine any improvement in areas of concern.
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		▪ The external general medical audit review process for Round #6 reviewed 12 records randomly chosen by the Facility's QA Department, which was 5.7% of the records at the Facility. Additionally, nine records were randomly chosen by the Facility's QA Department for the medical management audit. ▪ A Medical Provider Exit Interview was not conducted at the end of the audit as the auditor needed to return to his Facility. ▪ A review of findings was discussed at the medical services department meeting of 8/29/12. The State Office reportedly had hired two new physicians to complete the external medical peer reviews only. This was anticipated to provide a consistent review across all SSLCs and created the need for the establishment of inter rater reliability between the two physicians, rather than attempting to track and improve inter-rater reliability for all the physicians in the SSLC system that participated in the audit process. It also allowed the PCPs to remain in their SSLCs with less interruption to their work schedules. With regard to follow-up: ▪ A follow-up system was initially implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ Compliance data with corrective action plans was reviewed. These included 14 corrective action plans were from both the external and internal medical peer review audits. Two corrective action plans derived from the external medical peer review audit of August 2012, 10 were derived from the internal medical peer review audit of August 2012, one from the external medical management peer review audit of August 2012, and one from the internal medical management peer review audit of August 2012. ▪ From the May 2012 internal medical peer review audits, there were 30 corrective action plans derived from the internal medical peer review audit and 11 corrective action plans derived from the internal medical management audit, according to the raw data submitted. The total number of corrective actions was 41. ▪ From the February 2012 external medical peer review audit, there were 49 corrective action plans derived from the external medical peer review audit and eight corrective action plans derived from the external medical management peer review audit. The total number of corrective action plans was 57. ▪ There was no information submitted verifying that the QA Department tracked corrective action plan resolution every 30 days until resolution for these 112 corrective action plans. The "Action Plans and QA Follow–up" did not include any QA dates, QA comments, or completion dates.	

#	Provision	Assessment of Status	Compliance
		Mortality Reviews At the time of the review, the Facility had no outstanding clinical death reviews. There were no outstanding administrative death reviews. Since the start of the Monitoring Team's last visit, two deaths had occurred: ▪ The average age was 46 (varied from 41 to 50). ▪ Two of two died under the age of 65. ▪ Of the deaths, two were females, and none were males. ▪ The causes of death were: chronic respiratory failure with pneumonia, and chronic bowel obstruction and pelvic abscesses. ▪ An autopsy was performed in none of the two. ▪ DNR status was ordered while residing at LBSSLC for one of the two, and ordered for one of two while in the hospital. ▪ One died at the Facility. ▪ One died at another site (rehabilitation center) ▪ None had J-tube placements and one had a G-tube. ▪ Two included documentation indicating they had been aggressively treated earlier during hospitalization. ▪ Two were enrolled in hospice. ▪ None were considered ambulatory. Two were considered non-ambulatory. ▪ Two used oxygen supplementation. Since the Monitoring Team's last visit: ▪ Two clinical death review investigations were completed. Of these, one of two had one follow-up recommendation. ▪ Two administrative death reviews were completed. Administrative death reviews included four recommendations each that needed follow-up, for a total of eight recommendations. ▪ Systemic issues related to potential improvements in medical care were the focus of the recommendation from the clinical death reviews. ▪ Systemic issues related to potential improvements in health care were eight of eight recommendations from the administrative death reviews. ▪ The Facility submitted follow-up documentation for eight of eight administrative death review recommendations. The one recommendation from the clinical death review did not appear to have any formal in-service for this recommendation. The recommendation did not include a roster of attendance at the clinical death review to determine if all PCPs were in attendance. As a result, it could not be determined if further in-service discussion was needed. It is recommended that in the future, the clinical death review committee recommendations include the attendance of participants. Training should occur for those PCPs not in attendance.	

#	Provision	Assessment of Status	Compliance
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.	Inter rater reliability of external and internal medical peer review audits The Facility provided inter-rater reliability of individual case reviews selected for the medical peer review audit from August 21 to 28, 2012. All 12 individual audit results were reviewed, some of which were identified to have need for corrective action plans. For the individual cases, inter-rater reliability between the external auditor and the internal auditor ranged from 90% to 100%. The Facility provided inter-rater reliability of individual case reviews selected for the medical management audit (i.e., constipation, seizures, urinary tract infection) from August 21 to 24, 2012. All nine individual audit results were reviewed, some of which were identified to have need for corrective action plans. For the individual cases, inter-rater reliability between the external auditor and the internal auditor ranged from 80% to 100%. Facility's QA Department Review System No information was submitted indicating the role of the QA Department in monitoring the Medical Department. Although there was a role to follow up on corrective action plans from the medical peer review audits, there was no information submitted to verify this had occurred. Medical Department Internal Reviews Using the same audit tools as the external peer review auditor, the Medical Department completed an internal medical peer review audit and internal peer review medical management audit of clinical indicators for constipation, seizures, and UTIs from August 23 to 28, 2012. The Medical Director reviewed six records and the other PCPs each reviewed five records. The Medical Director prepared a summary report. Areas that appeared to need additional improvement included the following: "The Active Problem List was found to need updating in three of 12 records. Documenting a rationale for not following the pharmacist's recommendations on the QDRR was lacking in two of 12 records. Legibility was an issue in three of 12 records. In the Clinical Guideline Constipation, one record lacked documentation regarding the PCP documenting the effectiveness of treatment." Strengths were also identified, including: "Improvement was noted in documentation on the Active Problem List. Preventive Care was well documented. Labs, x-ray reports, and consultations were all signed and dated. A corresponding IPN was documented for findings, especially significantly abnormal results. Acute care issues and follow up care post ER/Hospitalizations was appropriate and timely. Care was appropriate regarding the Clinical Guidelines."	Noncompliance

#	Provision	Assessment of Status	Compliance
		On 8/29/12, the results of the internal peer review of August 2012 were discussed at a medical services department meeting. <u>Medical Department Initiatives and Improvement Projects</u> The Medical Department created a number of audits to track quality care and impact of corrective actions taken. For example: ▪ The Facility began to track consult recommendations to determine whether recommendations were completed. From 1/7/2012 through 8/2/12, 137 consultations with recommendations were identified. Of these, eight (5.83% sample size) were reviewed to determine whether the recommendations were completed. Of the eight consultations with recommendations chosen, seven of eight (87.5%) were identified as having been completed. ▪ Additionally, for the months of July through August 2012, four of a random sample of 56 consultations was chosen to determine if the consultant recommendations were reviewed within five business days of receipt. It was determined that compliance was 100%. It was further noted that written recommendations were reviewed within one day of receipt. Several in-service trainings were held for PCPs/psychiatry to assist in explaining the various audit questions, the measurement of compliance, and any additional steps needed to track compliance. One in-service was dated 7/12/12 and included the guideline to complete the PCP review of QDRRs within 15 days after the pharmacist had dated the document, documenting in an IPN when an intervention was required based on lab and diagnostic test results, legibility of documentation, and notifying the Medical Compliance Nurse when a medical quarterly progress note is completed. An undated in-service included a review that orders need an indication and duration for processing, reviewing consults with recommendations within five days (with further guidance when there is agreement or disagreement with the recommendation), and providing the necessary detailed information on consultant forms for offsite visits. An in-service was held on 8/2/12 concerning the revised policies: "LbSSLC – Health Services: Routine Laboratory Tests for Individuals," "LbSSLC – Health Services: Laboratory and X-ray Services," and "LbSSLC – Health Services: Allergy Documentation." Additionally, the Medical Department tracked Emergency Room visits and hospitalizations. On 7/26/12, a document entitled "Corrective actions related to second quarter emergency room visits and hospitalization data" was reviewed at the provider morning meeting. The number of ER visits was reviewed, the two most common reasons for the ER visits (i.e., musculoskeletal and gastrointestinal), and a review of those with falls and gastrostomy complications as subsets of these common reasons for the ER visits to determine any corrective actions. Similarly, the number of hospitalizations was reviewed, indicating an increase in the number of cases of dehydration, and also those	

#	Provision	Assessment of Status	Compliance
		with respiratory concerns. Behavioral Services was to follow up with one of the individuals that had dehydration with focus on preventive measures. There were no other clear/concise corrective actions identified with follow-up due dates. The Medical Department had identified additional clinical indicators for quality care monitoring for several diagnoses. At the time of the Monitoring Team's visit, they had not been implemented or used to begin to measure the quality of care. It will be important to identify clinical indicators for a wide range of diagnoses common to the IDD population residing at LBSSLC. The development of clinical guidelines with measurement tools to identify success in treatment and resolution of illness or optimization of care would allow more diagnoses to be monitored at periodic intervals. This would guide the PCPs and the IDTs in determining success of treatment or the need to review additional options. The Facility appeared to have begun to make advances in monitoring medical care at LBSSLC, with database review of hospitalizations and ER visits to determine the most common reasons for the admission or ER visit, as well as high rates of compliance in the general medical audits. However, this process should be expanded to assure quality with other areas of medical care, including routine care, preventive care, timely care for early change in health status, acute care, post hospital care, and palliative care. As part of Section L.3 requirements, the Medical Department will be required to analyze the data once it is collected, to determine trends, define potential reasons for the trends, and implement action steps to improve care, or to change a system of care, etc., depending on the concern identified. This aspect was beginning to occur with the Medical Department quarterly reviews of hospitalizations and ER visits, but action steps based on this information were minimal, in part due to an insufficient time period in which to determine trends. The response to action steps should be monitored to determine if the desired outcome is achieved, and adjust the action plan according to the outcomes. Providing a quarterly report of all new information and updates in the prior three months would allow the PCPs, other professional departments, and the Facility Administration to understand the strengths of the department, and identify areas in which a more interdisciplinary approach might be more effective.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally	Since the Monitoring Team's last visit, the following policies/procedures/protocols were implemented: ▪ The Medical Department implemented a policy entitled LBSSLC – Health Services Medical Peer Review, dated 8/29/12, with training on 9/5/12. ▪ The Medical Department implemented a protocol entitled Protocol for Blood Draws in Labs, dated 6/13/12, which provided additional steps to ensure a successful lab appointment, as well as documentation in the active record and	Noncompliance

#	Provision	Assessment of Status	Compliance
	accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	follow-up of the venipuncture site in the home. ▪ The Medical Depart submitted a document entitled Reclast Process Steps, dated 7/20/12, which documented the 22-step process to ensuring successful treatment of this medication. In-service occurred on 7/30/12 for the PCPs, Medical Department staff, Pharmacy and Dental Departments, and from 8/24/12 through 8/31/12 for the Nursing Department. The Medical Department had a policy for medical care: SSLCs Policy: Medical Policy, Policy # 009.1, dated 2/16/11. There had not been any changes in this policy since the Monitoring Team's last visit. There was an additional Facility policy: LSSLC – Health Services: Medical Care, dated 2/11/2011. There had not been any changes in this policy since the Monitoring Team's last visit. Since the last monitoring team visit, the following policies/procedures/protocols were amended: ▪ LBSSLC – Health Services: Routine Laboratory Tests for Individuals, (date revised was inaccurately typed); ▪ LBSSLC – Health Services: Laboratory and X-ray Services, (date revised was inaccurately typed); and ▪ LBSSLC – Health Services: Allergy Documentation, (date revised was inaccurately typed). There was an in-service provided on 9/5/12 and 9/6/12 to the PCPs, and Pharmacy and Dental Department Directors for a revised policy entitled LBSSLC – Review Processes: Quality Assurance Process/Plan, dated 8/30/12. There was an in-service provided on 9/5/12 and 9/6/12 to the PCPs, Medical Department staff, Pharmacy and Dental Department Directors for a revised policy entitled LBSSLC- Health Services Emergency Medical Response Drills, dated 8/30/12. As the State Office develops and issues clinical guidelines, LBSSLC will need to be prepared to implement them, and modify its policies and procedures to be consistent with the guidelines. It will be important for the Department to ensure the policies and procedures reflect the system changes. For instance, a policy should be created to reflect the process of the provider morning meeting, the referral process through the QDDP Educator to the IDTs, the response of the IDT within a certain time period with the creation of an ISPA if applicable, critical review of the ISPA to ensure it answers the concern of the morning meeting team, and the documents required to reflect closure. Additionally, assignment of	

#	Provision	Assessment of Status	Compliance
		tasks to the members of the committee with deadline due dates should be another part of the policy. The mandatory representation from selected departments should be listed in the policy. Clinical guidelines also should be expanded to include the common medical diagnoses of the population residing at LBSSLC. This can be determined by reviewing the active problem lists to determine the most common diagnoses, and beginning to develop guidelines with the goal of uniformity of timeliness of response, standard work up, initial treatment options, and a determination of what consultants might be needed (on site and off site), as well as when they would be consulted. The guidelines would also be useful to Section L.3 when clinical indicators and measurement tools are incorporated in tracking progress of treatment. In summary, the Medical Department had created some processes, and there should be policies and procedures that reflect these endeavors. Additionally, expanding the clinical guidelines to other common diagnoses would ensure provision of medical care across a broad range of diagnoses, once these guidelines are implemented.	

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

1. The Facility should ensure the completion and timely filing of annual medical assessments prior to the ISP. (Section L.1)
2. The PCPs should provide guidance for the most significant diagnoses for entry onto the DG-1 form. (Section L.1)
3. The QA Department should monitor the quality and completeness of the quarterly medical review document. (Section L.1)
4. The Medical Department should determine and review the causes for and implement action steps 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)
5. 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)
6. 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. (Section L.1)
7. 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)
8. To assist with the process of tracking missed appointments, the Medical Department should generate a database report with focus on specialty appointment (rather than location of appointment or test, and rather than name of individual specialists which might not be further identified by specialty). It would be helpful to list appointments per specialty to determine referral patterns to specialties. The report should also summarize the number of appointments, number of completed appointments, reasons for missed appointments, and follow-up of missed appointments to determine when the individuals successfully completed the specialty visit. (Section L.1)
9. The Facility should track the timely completion of pap smears in the eligible population, including whether prior pap smears were normal and justified three year (or more) interval testing schedules, as well as recording whether hysterectomies were due to non-malignancies.
10. Future tracking for osteoporosis/osteopenia should clearly identify which individuals are diagnosed with osteopenia and which were

diagnosed with osteoporosis. (Section L.1)

11. For those individuals with a T score less than -1.0 and greater than -2.5, the drug regimen and risk profile for development of osteoporosis should be reviewed to ensure appropriate/optimal dosage of these various classes of medication. (Section L.1)
12. 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)
13. The Medical Department should review ensure accuracy of information in databases. (Sections L.1 and L.3)
14. 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)
15. 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)
16. 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)
17. The medical staff should review the route of orders for those with J-tubes and G/J tubes to ensure that the orders are consistent with the type of feeding tube present, consistent with the functional abilities of the individual, and consistent with the Pharmacy Department's recommendations for the individual and need for additional monitoring, etc. (Section L.1)
18. For those individuals with a terminal condition, the Facility is encouraged to utilize a structured approach to discussing and documenting 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. (Section L.1)
19. Based on the State Office guidelines, it would be helpful to summarize the lengthy meeting minutes of the LBSSLC ethics committee into a succinct statement of the qualifying condition that meets the State Office guidelines for the DNR status. This would be useful for any future reference in reviewing appropriateness of DNR status. (Section L.1)
20. 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)
21. Keeping internal and external audit information separate would be helpful in providing evidence that fulfills the requirements of the Settlement Agreement. Causes for differences in the external and internal audits should be determined. (Section L.2)
22. For each of the internal and external audits, Medical Department initiatives should be implemented to resolve and prevent deficiencies. (Section L.2)
23. 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 in next steps, as well as provide documentation of progress consistent with the goals of the Settlement Agreement. (Section L.2)
24. Clinical indicators should be determined to monitor quality care from a variety of perspective (e.g., timeliness of treatment, lab tests completed, medications chosen, documentation, consents, outcomes for individuals, etc.). Priority should be on those clinical issues that lead to ER visits, hospitalizations, and poor quality of life. (Section L.3)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o LBSSLC's Self-Assessment; o LBSSLC's Provision Action Information; o LBSSLC At-Risk Individuals list; o LBSSLC's Nursing Department Presentation Book; 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 #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #276, Individual #160, Individual #74, Individual #235, Individual #94, Individual #220, Individual #52, Individual #204, Individual #232, Individual #136, Individual #164, Individual #312, Individual #183, Individual #178, Individual #1, Individual #13, Individual #59, Individual #316, Individual #107, Individual #237, Individual #221, Individual #4, Individual #99, Individual #290, Individual #226, Individual #25, Individual #274, Individual #89, Individual #280, Individual #43, Individual #16, Individual #75, Individual #238, Individual #15, Individual #299, Individual #113, Individual #57, Individual #17, Individual #50, Individual #109, Individual #160, Individual #43, Individual #56, and Individual #164; 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 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 Infection Control Committee meeting minutes; o Infection Control data reports by month, home, and person; o Monthly Residential Rounding data; o LBSSLC Discrepancy Reports; o Drug Utilization Discrepancy Reports; o Medication Observation raw data; o Draft of Medication Administration Observation weighted tool; o 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 8/23/12; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 6/27/12; ○ 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; and ○ Residential Coordinator Medication Pass monitoring forms and data. ▪ **Interviews with**: ○ Jeremy Ellis, RN, BSN, Chief Nurse Executive; ○ Eddie McFadden, RN, QE Nurse; ○ Michelle McElroy, RN, Infection Control (IC); ○ John Todd, R.Ph., Clinical Pharmacist; ○ Mary Ortiz, Competency Training Department (CTD); ○ Robin Seale, Assistant Director of Programs; ○ Dawn Ripley, Quality Assurance Director; ○ Ruth Clark, RN, Quality Assurance Nurse; ○ Mike Parks, RN, Assistant Nurse Educator; and ○ Matt Peterson, Training Specialist. ▪ **Observations of**: ○ Medication Administration in Quail and Sparrow; ○ Use of emergency equipment at Quail, Sparrow, and 514 Birch; ○ Medication Safety and Systems Committee meeting, on 9/2/12; and ○ Pharmacy & Therapeutics Committee meeting, on 9/2/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section M, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. At the time of the review, the Facility indicated that in May 2012, the monitoring for a majority of the areas for nursing was suspended due to staffing issues and turnover in key leadership positions in nursing. However, the monitoring regarding Medication Administration Observations and "Real Time" Infection Control audits were continued throughout the review period. Consequently, there was little data available for review or analysis. In addition, at the time of the review, the CNE and QA Nurses were in the initial process of monitoring some select areas in nursing in order to determine the status of a number of systems related to the provisions of Section M of the Settlement Agreement. However, based on the data and information contained in the Facility's Self-Assessment: ○ It was unclear at times why some of the data was included under certain provision that were not related to the specific elements of the provision.

	- Overall, much of the data presented for many of the sub-sections for Section M did not reflect the quality of the documentation as was focused on by the Monitoring Team's findings. As the Facility resurrects its monitoring systems for nursing, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. - In addition, since there had been significant turnover in many of the nursing positions, the Facility will need to address processes regarding establishing inter-rater reliability for each of the monitoring tools. An important component of inter-rater reliability is ensuring that the current monitoring/audit tools have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Without establishing inter-rater reliability, it was likely that different auditors would, score compliance differently without executing this process. - The Self-Assessment identified the sample sizes. However, it did not include the description of the overall population from which the sample was selected (N) or present a percent sample size. From the numbers that were provided, it did not appear that these samples sizes were adequate to consider them representative samples. - In addition, it should the staff/positions that were responsible for completing the each of the audit tools should be clearly identified. - Also, it should be clear from the documentation provided that the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and/or were programmatically competent in the relevant areas. - The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis and provide training to the disciplines regarding how to analyze their data to identify problematic trends. - The Facility rated itself as being in compliance with none of the sub-sections of Section M. This was consistent with the Monitoring Team's findings. However, of concern, some of the indicators included in the Self-Assessment showed high levels of compliance, which was not consistent with the Monitoring Team's findings. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reason for this discrepancy. - The Facility's data identified areas in need of improvement. However, for some of the areas that were identified as areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: Since the last review, nursing staffing continued to be a significant challenge for the Facility, with turnover in a number of positions as well as in the key leadership nursing positions. Due to these staffing issues, the Facility had to utilize Agency nurses to cover some of the vacant positions, and continued to do so at the time of the review. In addition, LBSSLC had some changes regarding the Nursing Department and nursing positions. For example, a new Chief Nurse Executive was appointed in May 2012; a new Nurse Operations Officer was hired in June 2012; a full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position in August 2012; a new full-time Hospital Liaison was appointed in July 2012; an Assistant Nurse Educator was hired in July 2012; and the existing

	Nurse Educator (RN) moved to a position as the Quality Assurance Nurse in May 2012. Some of the Facility's positive steps forward included: ▪ An administrative nursing on-call rotation was developed and implemented; ▪ Job expectations were reviewed with Case Managers and Shift Supervisors; ▪ 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. ▪ Protocol Stickers were implemented in July 2012 to prompt nurses to conduct and document the appropriate clinical assessments for specific health issues. In addition, the Facility had also implemented nursing protocol audits in August 2012. ▪ The Facility continued to utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues. ▪ On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in Quail, Sparrow, and 514 Birch found that all staff were familiar with the use and operation of the emergency equipment, which was a significant improvement from previous reviews. ▪ In August 2012, the Facility implemented a very positive procedure that included requiring the nurses to bring the Medication Administration Records (MAR) to shift change for the off-going and on-coming nurse to review the MAR for blanks and/or omissions. At the time of the review, nursing was focused on determining the baseline for a number of the nursing systems and Settlement Agreement requirements in order to develop a prioritized plan for moving forward. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, and the quality of the quarterly and annual Comprehensive Nursing Assessments were very concerning at this juncture in the review process. As candidly reported by the CNE and Facility Director, the challenges in stabilizing the nursing coverage related to staff turnover, and the necessary changes made in the nursing leadership positions since the last review had prevented the Facility from making more progress. However, it is the hope of the Monitoring Team that the time the Facility took to assess its nursing systems will result in an appropriately prioritized plan with sustainable positive systems and outcomes.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems,	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In assessing its progress, LBSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ Since the last review, the Nursing Department experienced an increase in staff turnover as well as in the key leadership roles. Due to these staffing issues, the Facility had to utilize Agency nurses to cover some of the vacant positions. In addition, these staffing challenges led to the decision to suspend the auditing processes for the nursing monitoring tools except for the "Real Time" Infection Control audits and the Medication Administration Observations. Consequently, there was little data available for review or analysis. ▪ A nursing skills fair was held to ensure that nurses received the required annual competency training. The Facility's Training rosters indicated that 78% of the nurses completed the necessary competency evaluations. The CNE reported that the Assistant Nurse Educator was developing a plan to ensure the remaining nurses completed the required training. Additional steps implemented by the Facility are noted below in the associated specific areas. <u>Self-Rating</u> The Facility's Self-Assessment indicated that "based on this self-assessment, this provision is not in substantial compliance because nurses are not yet documenting per the approved nursing protocols in their entirety to better address and identify health care problems, proper notifications and follow-up to readily identify the changes in status. In addition, there is lack of monitoring, trending, and/or analysis being completed to determine compliance." <u>Staffing</u> At the time of the review, LBSSLC had a census of 211 individuals. Since the last review, LBSSLC had a number of staffing changes regarding the Nursing Department and nursing positions, which included: ▪ A new Chief Nurse Executive was appointed in May 2012; ▪ A new Nurse Operations Officer was hired in June 2012; ▪ A full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position in August 2012;	

#	Provision	Assessment of Status	Compliance
		▪ A new full-time Hospital Liaison was appointed in July 2012; ▪ An Assistant Nurse Educator was hired in July 2012; ▪ The existing Nurse Educator (RN) moved to a position as the Quality Assurance Nurse in May 2012; and ▪ Recruitment efforts were in place to fill the full-time Nurse Educator position at the time of the review. In addition, at the time of the review, the Nursing Department had a total of 95 allotted positions. The nursing vacancies included three RN positions and three LVN positions. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive, since the last review, LBSSLC had experienced significant turnover in nursing staffing for both RN and LVN positions. Due to the variability of the nursing staffing fill rates, especially since April 2012 when the fill rate decreased to 86.6%, the Facility had to engage the services of two local Agencies in order to have nursing coverage for all shifts. At the time of the review, the Facility had decreased its use of Agency nurses, but continued to utilize their services to cover some of the vacant positions. In addition, the CNE reported that in order to foster a positive change in the culture for the Nursing Department, the following actions had been taken: ▪ An administrative nursing on-call rotation was developed and implemented; ▪ Shift supervisors were given the authority to make decisions regarding staffing needs; ▪ A "Pull Log" was developed to monitor and track when nurses were required to work on units different than their assigned units to aid in assessing continuity of care and staff morale issues; ▪ A nursing retention questionnaire was recently developed to assess job satisfaction for the current nursing staff; and ▪ Job expectations were reviewed with Case Managers and Shift Supervisors. Although the Facility had experienced not only an increase in staff turnover as well as significant changes in key nursing leadership positions, the CNE reported at the time of the review that the overall nursing staffing issues had begun to stabilize at LBSSLC. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as previously recommended, as LBSSLC policies and systems are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. <u>Quality Enhancement Efforts</u> From discussions with the CNE and Quality Assurance Nurses, since the last review, the following activities had been initiated:	

#	Provision	Assessment of Status	Compliance
		▪ Changes in the nurses in the QA Department included one of the existing QA Nurses moving into the CNE position, and the existing Nurse Educator moving into the vacant QA Nurse position in May 2012. ▪ Monitoring of Acute Illness and Injury/hospitalizations as well as most of the other nursing monitoring tools, with the exception of the Real Time Infection Control audits and Medication Administration Observations had been suspended due to changes in nursing administration and key leadership positions. At the time of the review, the CNE and QA Nurses were in the initial process of monitoring some select areas in nursing in order to determine the status of a number of systems related to the provisions of Section M of the Settlement Agreement. ▪ Also, the CNE reported that the state database had not been kept updated in alignment with policy changes. This caused problems with data entry and data accurately matching the items on the monitoring tools and the statewide database items. ▪ Although monthly meetings between the CNE and QA Nurses recently had been initiated, there were no minutes kept to validate these meetings or the issues 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. The protocols should be integrated into the instructions for the monitoring tools. Clearly, at the time of the review, nursing was focused on determining the baseline for a number of the nursing systems and Settlement Agreement requirements in order to develop a prioritized plan for moving forward. As candidly reported by the CNE and Facility Director, the challenges in stabilizing the nursing coverage related to staff turnover, and the necessary changes made in the nursing leadership positions since the last review had prevented the Facility from making more progress. However, it is the hope of the Monitoring Team that the time the Facility took to assess its nursing systems will result in an appropriately prioritized plan with sustainable positive systems and outcomes. <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: ▪ Although as noted above, the Facility reported that monitoring for this area had been suspended, the Facility reported that 99 of 99 nurses (100%) had been	

#	Provision	Assessment of Status	Compliance
		provided verbal instruction regarding using the nursing protocols in May 2012. However, as noted from the past review, there was no evidence found by the Monitoring Team that the protocols were being used to develop HMPs and guide nursing documentation. In addition, the Monitoring Team's findings from the current review found extremely limited evidence that the nursing protocols were being used. ▪ The Facility's Self-Assessment indicated that Protocol Stickers were implemented in July 2012 to prompt nurses to conduct and document the appropriate clinical assessments for specific health issues. In addition, the Facility also had implemented nursing protocol audits in August 2012, sampling 18 records (n) out of 214 (N) for an 8% sample size and found that six (33%) of 18 had proper protocols implemented. Although the sample size was very small, it was unclear how the sample was selected, how the Facility measured compliance, and what was specifically meant by "had proper protocols implemented." In addition, the compliance score obtained by the Facility (33%) regarding the implementation of nursing protocols was significantly higher than was found by the Monitoring Team. A review of 10 individuals' medical records (i.e., Individual #258, Individual #136, Individual #181, Individual #113, Individual #149, Individual #33, Individual #323, Individual #324, Individual #2, and Individual #90) who had been transferred to a community hospital, or emergency room found: ▪ Nurses promptly and consistently performed a physical assessment on an individual displaying signs/symptoms of potential or actual acute illness in none (0%) of the cases. ▪ 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 nurse consistently performed appropriate and complete assessments as dictated by the symptoms in alignment with nursing protocols in none (0%) of the cases. ▪ The nurse 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. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 10 individuals found basically the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team	

#	Provision	Assessment of Status	Compliance
		identified during the past five reviews. The overall problematic issues that were found in the 10 records included: ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments and documentation of the findings from assessments; ▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in behaviors, vital signs, and oxygen saturations; ▪ The lack of consistent nursing documentation made it impossible to accurately determine when changes in status were initially occurring; ▪ There was a consistent lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (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 lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any associated changes in mental status from 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 individuals with 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; ▪ 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 individuals; ▪ Many inappropriate abbreviations were used 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; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility;	

#	Provision	Assessment of Status	Compliance
		▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ Nursing Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although the Facility reported that Nursing Protocols had been implemented, the Monitoring Team found no indication that they were being used to guide nursing assessments and documentation. Although there were some Integrated Progress Notes (IPNs) that contained adequate nursing assessments and associated findings, the inconsistency of these adequate notes clearly indicated that these were not the result of a structured system. 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 continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the expanded use of the protocols. As noted in past reports, due to the number of individuals with complex medical needs at LBSSLC, this area should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in compliance with these 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 a number of the Comprehensive Nursing Assessments were missing from the active records. 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.	

#	Provision	Assessment of Status	Compliance
		Infection Control (IC) From the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse, review of other documentation, and observations during the review, some positive steps forward had been made regarding the process of continuing to build an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ The Facility continued to utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by the Drug Utilization Discrepancy Reports, overall discrepancies since the last review had decreased. This decrease not only reflected a very positive step forward in tracking discrepancies regarding Infection Control information to ensure data reliability, but also a positive increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports completed by the residential staff. ▪ The Facility's Immunization database was completed including data for all 211 individuals' immunizations. However, at the time of the review, the Nurse Case Managers were in the process of verifying the data entered. In addition, the Facility's Self-Assessment indicated that tracking, trending, and analysis of the data was in the developmental stages and not available for review. ▪ As of 8/20/12, the Facility reported that a review of Tuberculosis screenings indicated that 214 (100%) of 214 residents, 100% of the Foster Grandparents, and 827 (99%) of 831 staff members were in compliance. In addition, a review of the last seasonal flu/H1N1 virus immunizations indicated that 212 individuals (99%) of 214 received appropriate immunizations. The two individuals that did not receive the immunizations were due to guardian refusals. ▪ The documentation regarding the Outbreak Investigations since the last review continued to improve. Improvements included the amount of details provided, and the integration of this information into the Infection Control Committee meeting minutes. ▪ Documentation the Facility provided verified that since the last review, the Infection Control Nurse had provided a number of clinically appropriate in-service trainings addressing various infection control issues. ▪ A review of the "Real Time" Infection Control monitoring tools included some specific comments regarding both positive and negative findings. A review of the raw data indicated that some significant problematic issues were found, especially regarding the lack of adequate nursing care plans addressing the infectious illness. However, there was no indication that these data were being aggregated and analyzed along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility.	

#	Provision	Assessment of Status	Compliance
		▪ The Infection Control Nurse attended the International Association for Professionals in Infection Control (APIC) Conference in June 2012. Although the IC Nurse made several positive steps forward, there continued to be a number of significant problematic areas regarding infection control that were in need of further attention, including; ▪ Although the Facility had developed and had been updating the Facility's immunization database, consistent with past reviews, the Facility could not generate a list of all the individuals whose past immunizations had been researched, and were updated, as appropriate. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. ▪ The results of the "Real Time" Infection Control audits were not trended or analyzed in conjunction with other IC data to determine if there was a correlation between the problematic issues found during the audits and rates of infections. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. ▪ At the time of the review, Infection Control was not conducting any Environmental Surveillance Surveys, although Risk Management was currently conducting them. However, there was no trending or analysis of this data found in the minutes of the Infection Control Meeting minutes. ▪ Of major concern and consistent with the same significant issues found during the previous five reviews was the lack of nursing care plans or adequate nursing care plans found regarding infectious diseases (more specific details of the Monitoring Team's findings are discussed with regard to Section M.3). Although the Infection Control Nurse had reviewed a number of nursing care plans and included good clinical comments and recommendations for modifications, nursing did not make the necessary changes in order for the care plans to be considered clinically adequate. Although the Facility continued to make some solid positive steps forward regarding Infection Control, there continued to be a significant amount of work yet to be done, especially regarding nursing care plans addressing infectious illness. As noted in previous reports, 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 and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program.	

#	Provision	Assessment of Status	Compliance
		Mock Code Drills and Emergency Response Systems Since the last review, LBSSLC indicated the following steps were initiated regarding this area: ▪ Since the last review, the Facility continued to conduct the required number of Emergency drills. ▪ The CTD staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data from April through August 2012 indicated that 78 of 81 total drills (96%) that were conducted were deemed as passing, which was a very positive finding. However, since the last review, the Facility had not been conducting alternative scenarios as was done in the past due to staffing changes that left the system unassigned. ▪ A review of the Facility's data indicated that regarding the required daily emergency equipment checks completed by nursing staff, in June 2012, 415 of 450 checks (92%) were completed, and for July 2012, 460 (99%) of 465 checks were completed. ▪ At the time of the review, the Facility was in the process of establishing inter-rater reliability for the Emergency Drill tool. ▪ Since the last review, the QA Nurse initiated emergency equipment drills for nursing after each Emergency Drill. ▪ On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in Quail, Sparrow, and 514 Birch found that all staff were familiar with the use and operation of the emergency equipment. This was a significant improvement from previous reviews. Although the Facility implemented some positive steps in addressing the Emergency Response System, there were a number of problematic issues found that should be addressed in order for additional progress to be made: ▪ Since the State Office Emergency Response policy was implemented in December 2011, there had been various interpretations regarding the role of the Risk Manager and checking the emergency equipment to ensure it was present or to see if it was operational. At the time of the review, the Risk Manager reported that he had been checking the emergency equipment to verify it was operational. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement addressing checking the emergency equipment. ▪ There was no analysis found regarding actual medical emergencies in conjunction with the data addressing Emergency Drills. ▪ Although the CTD staff reported improvement, there continued to be some staff resistant to participating in the Emergency Drills. ▪ During the review, it was found that the Emergency Equipment Competency	

#	Provision	Assessment of Status	Compliance
		Checklist that should be conducted at least every quarter for each nurse had not been regularly conducted. In addition, in residence 514 Birch, the suction machine gage cover was missing, indicating that it was not being regularly checked. ▪ Although the Facility had acquired eight new Automated External Defibrillators (AEDs) during the last review, the Monitoring Team noted that there were a number of areas in the Facility that did not have an AED or quick access to one. The Facility should consider assessing the need for acquiring additional AEDs to ensure that emergency equipment is readily available. The Facility had made some positive steps forward regarding LBSSLC's Emergency Response System. However, there continued to be some problematic issues as noted above that needed to be addressed.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. LBSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ Regarding activities addressing a review of data analysis generated from the monitoring tools for nursing assessments and the documentation validating compliance from record reviews, the Facility's Self-Assessment indicated that on 5/1/12, the monitoring of nursing assessments was temporarily suspended due to changes in new nursing administration/leadership positions. However, the Self-Assessment indicated that on 8/20/12, a review of the tracking log for the timely completion of the quarterly Nursing Comprehensive Assessments from May through July 2012 indicated that only 147 (69%) of 214 required assessments were completed within the appropriate timeframes. Regarding any corrective actions addressing Nursing Comprehensive Assessments, the Self-Assessment indicated that no data was available, because this system was in the developmental stages at the time of the review. ▪ Although not related to this provision, the Facility indicated that the Real-time Infection Control audits and Medication Administration Observations were continuing to be conducted, although any trending and analysis had not yet been implemented at the time of the review. ▪ Although the Facility indicated that as of 8/31/12, 27 RNs (52%) of 52 RNs had completed the training regarding the head-to-toe assessment class, and as of 9/15/11, 45 (94%) of 48 RNs completed the physical assessment class, it was unclear to the Monitoring Team if these were two different trainings addressing physical assessment since the number of RNs required to attend (N=52 and N=48) were noted to be dissimilar, and the dates were only a couple weeks	Noncompliance

#	Provision	Assessment of Status	Compliance
		apart. Although not clear in the documentation the Facility originally submitted, in its response to the draft report, the State explained this discrepancy was due to changes in actual staffing numbers. ▪ On 9/17/12 and 9/18/12, a nursing skills fair was conducted to provide training for all nurses to complete required annual competencies. The Monitoring Team was able to validate this information included in the Facility Self-Assessment by reviewing training rosters the Facility provided in the Section M Presentation Book. ▪ Regarding nursing transition/discharge assessments, the Facility reported that a review of all six (100%) nursing transition/discharge summaries from March through August 2012 found that six (100%) of six utilized the Nursing Discharge Summary form, and none (0%) of six had specific enough instructions included regarding the individuals' identified risks to maintain adequate care upon transition, which was consistent with the findings from the Monitoring Team noted below. <u>Self-Rating:</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because nursing comprehensive assessments are not consistently done on a quarterly basis and there is a lack of adequate monitoring for thoroughness of assessments." A major concern for the Monitoring Team was that thus far in the review process, LBSSLC had not generated findings addressing the quality of the documentation contained in the Comprehensive Nursing Assessments, which continued to be inadequate. Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below, were far more specific regarding the significant problems with the quality and content of the Comprehensive Nursing Assessments than what was reflected in the Facility's Self-Assessment. In addition, the Facility's Action Plan addressing Section M.2 did not include any action steps regarding the poor quality of the Comprehensive Nursing Assessments or how it was to be addressed by the next review. The Quarterly/Annual Nursing Assessments for 22 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #283, Individual #51, and Individual #282 for dental issues; Individual #308, Individual #165, and Individual #298 for constipation; Individual #324, Individual #276, and Individual #160 for cardiac issues; Individual #74, Individual #235, Individual #94, and Individual #220 for weight issues; Individual #52, Individual #204, and Individual #232 for osteoporosis; Individual #136, Individual #164, and Individual #312 for	

#	Provision	Assessment of Status	Compliance
		fractures; Individual #183 for ear infections, Individual #178 for PICA, and Individual #1 dementia. ▪ Of the 22 individuals' nursing quarterly assessments reviewed, eight (36%) were timely completed. Assessments not timely completed included those for: Individual #283, Individual #51, Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #74, Individual #204, Individual #232, Individual #164, Individual #312, Individual #178, and Individual #1. ▪ 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. Although the Facility began tracking the timely completion of the Comprehensive Nursing Assessments and had presented some initial findings regarding timeliness, the Monitoring Team found that essentially no progress had been made regarding the quality of the quarterly/annual nursing assessments. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate or appropriate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving or getting worse. Although the challenging problems regarding nursing staffing and the turnover in key nursing positions was noted in the Facility's Self-Assessment and candidly reported during interviews with Nursing Department and Facility Administration, the consistent lack of progress found by the Monitoring Team regarding the Comprehensive Nursing Assessments, was of significant concern due to the potential impact it had on the health and wellbeing of individuals the Facility supported. The Facility had not yet established a concrete plan to address this requirement, but this should be a top priority for the new Nursing Department's administration. It is essential that nurses responsible for quarterly assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care were actually making progress regarding their health status. 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. As noted in previous reports, without providing adequate and appropriate competency-based training and ongoing mentoring regarding the process and documentation of a	

#	Provision	Assessment of Status	Compliance
		clinical analysis, it is unlikely improvement will be seen in the quality of the Comprehensive Nursing Assessments as required by the Settlement Agreement. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the Nursing Discharge Summaries for six individuals including: Individual #13, Individual #59, Individual #316, Individual #107, Individual #237, and Individual #221 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the 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 at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. As noted in previous reports, a number of problematic issues found during past reviews continued to be found in all six Nursing Discharge Summary Assessments reviewed, including: ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community; ▪ 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; ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals; and ▪ Discrepancies in recommended treatments and services between the nursing documentation and documentation from other disciplines that was not discovered and reconciled prior to the community transition. The consistent problematic findings regarding nursing transition/discharge documentation identified through the Monitoring Team's review, which was similar to the Facility's audit findings, at this stage of the review process was extremely concerning. The chronic lack of attention to this area indicated a lack of recognition from nursing as well as the teams that the more information 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 individual's transition/discharge from the Facility, the nursing documentation is specific	

#	Provision	Assessment of Status	Compliance
		and detailed enough to maintain continuity of care. As noted in past reports and during past reviews, the problematic issues regarding the quality and content of the nursing assessments for discharges/transitions to the community had not been positively impacted by the implementation of a new state-wide form. It was troubling that from review of the Facility's Action Plans and discussions with the CNE, the Facility had no plan in place to address this area by the next review. In addition, due to the poor quality of the Risk Action Plans/Health Management Plans (as discussed with regard to Section M.3), the Monitoring Team found no nursing documentation that provided specific guidance regarding the type and frequency of nursing interventions the individuals required. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision. This was consistent with the Facility's finding in its Self-Assessment.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. LBSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that due to changes in nursing administration and leadership positions, the monitoring of nursing care plans was suspended in May 2012 regarding the individualization of the Integrated Health Care Plans (IHCPs) and Acute Care Plans, the quality of the Health Management Plans and Acute Care Plans regarding individuals' risk indicators and/or potential risk indicators, and the review of the data analysis generated from monitoring tools related to nursing care plans. ▪ In addition, regarding activities addressing a review of documentation that indicated that direct support professionals were trained on the respective care plans and any corrective action plans developed to ensure compliance with the area of nursing care plans, the Self-Assessment indicated that there were no data available, because this system was in the developmental stages at the time of the review. ▪ Training rosters contained in the Section M Presentation Book verified that from 7/24/12 through 7/26/12, 14 (88%) of 16 RN Case Managers completed the State Office training regarding the Integrated Health Care Plan. ▪ From discussions with the Assistant Director of Programs and the Chief Nurse Executive, since the Monitoring Team's last review, two pilot residences, 504 W and 514, had made a transition from using the Health Management Plans to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace	Noncompliance

#	Provision	Assessment of Status	Compliance
		the current Risk Action Plans and Health Management Plans. The training rosters included in the Presentation Book for Section M verified that in August and September 2012, the State had provided the At Risk and ISP (Integrated Health Care Plan) training. Although the use of an Integrated Health Care Plan was a very promising clinical move forward for LBSSLC, it was of major concern to the Monitoring Team that the quality of the existing HMPs and Acute Care Plans had not improved since the last review as discussed in detail below. In addition, there was no plan in place at the time of the review addressing how nursing interventions for certain chronic conditions that did not rise to the level of a high or medium risk or were not acute issues would be accounted for in a plan of care. Self-Rating: The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because the current risk rating system combined with the Integrated Health Care Plan remains under development and there is not yet an adequate system to monitor and analyze its success." The records of 22 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #283, Individual #51, and Individual #282 for dental issues; Individual #308, Individual #165, and Individual #298 for constipation; Individual #324, Individual #276, and Individual #160 for cardiac issues; Individual #74, Individual #235, Individual #94, and Individual #220 for weight issues; Individual #52, Individual #204, and Individual #232 for osteoporosis; Individual #136, Individual #164, and Individual #312 for fractures, Individual #183 for ear infections, Individual #178 for PICA, and Individual #1 dementia. Of the 22 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Eleven (50%) were found to have a HMP addressing their high-risk health/mental health indicator. Individuals who did not have a related HMP included Individual #283, Individual #51, Individual #282, Individual #308, Individual #276, Individual #74, Individual #204, Individual #232, Individual #164, Individual #312, and Individual #183. ▪ None (0%) of the nursing goals listed in the 11 HMPs was clinically appropriate. ▪ None (0%) of the nursing interventions contained in the 11 HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. In addition, the overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. Also, the nursing interventions listed in the	

#	Provision	Assessment of Status	Compliance
		HMPs reviewed were not in alignment with nursing protocols addressing the specific health issues. ▪ None (0%) of the 11 HMPs were found to be clinically adequate. ▪ None (0%) of the 11 HMPs contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 11 HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 11 HMPs, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. As noted above, the Facility reported that they were in the process of transitioning from using the traditional nursing care plans (Health Management Plans) to using an Integrated Health Care Plan in the buildings that were conducting the pilot for the At Risk Individuals, Residences 504 W and 514. Although the use of an integrated care plan was a promising step forward for LBSSLC, the Facility had not yet addressed a number of problematic issues that could compromise this new system resulting in essentially the same significant problems as noted above within the current system. Specifically, some of the issues identified in the HMPs reviewed that the Facility will need to ensure are not repeated in IHCPs included the following: ▪ The rationale for several risk levels did not include the needed clinical justification to support the designated level. Consequently, it was difficult for the Monitoring Team to determine the accuracy of the risk levels and the need for action steps addressing the health risk. ▪ The nursing goals listed in the HMPs reviewed did not address the etiology of the health problem as an objective clinical indicator to focus on. Consequently, most action steps found in the HMPs did not address the underlying cause of the health issue and had no association with the nursing goals listed. ▪ None of the nursing action steps found in the HMPs were in alignment with the clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the HMPs did not include specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; consistently noting where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Overall, most of the nursing action steps continued to be meaningless in that they were at times generic, and non-specific to the individual's health care needs. ▪ At the time of the review, the HMPs reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized.	

#	Provision	Assessment of Status	Compliance
		Although the use of the IHCP was only recently implemented for the At-Risk pilot, many of the problematic issues noted above that have been found and not resolved with the existing HMPs have the potential of being transferred to the new IHCP system. Regardless of the system and system changes made to the Facility's overall plans of care, it is essential that the Facility address the lack of clinically adequate care plans for the individuals under their care. The Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at LBSSLC Regarding nursing care plans addressing infectious illness, the Infection Control Report the Facility provided to the Monitoring Team indicated there were 11 individuals with chronic infectious issues (i.e., Individual #15, Individual #299, Individual #113, Individual #57, Individual #17, Individual #50, Individual #109, Individual #160, Individual #43, Individual #56, and Individual #164). ▪ Of the 11 individuals, four (36%) were found to have had HMPs addressing the infectious issue. ▪ Of the four Nursing Care Plans reviewed, none were found to be adequate (0%). Regarding nursing care plans addressing other infectious illness, the Facility list indicated that since the Monitoring Team's last review, two individuals were diagnosed with MRSA (i.e., Individual #75, and Individual #238), and 10 individuals were diagnosed with Conjunctivitis (i.e., Individual #4, Individual #99, Individual #290, Individual #226, Individual #25, Individual #274, Individual #89, Individual #280, Individual #43, and Individual #16). ▪ Of the two individuals diagnosed with MRSA, one (50%) was found to have had an acute HMP addressing the infectious issue. The Individual who did not have an HMP addressing the infectious issue was Individual #238. ▪ Of the one Nursing Care Plan reviewed, none were found to be adequate (0%). ▪ Of the 10 individuals diagnosed with conjunctivitis, one (10%) was found to have had an acute HMP addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #4, Individual #290, Individual #226, Individual #25, Individual #274, Individual #89, Individual #280, Individual #43, and Individual #16. ▪ Of the one Nursing Care Plans reviewed, none were found to be adequate (0%). A review of the documentation from the Infection Control Nurse, including comments and recommendations she made to increase the clinical quality of some of these care plans was found to thorough and clinically sound. However, none of the plans had been modified in alignment with her recommendations, resulting in clinically inadequate nursing care plans addressing infectious illnesses.	

#	Provision	Assessment of Status	Compliance
		At the time of the review, 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. It was very concerning to find that individuals with contagious/infectious illnesses did not have care plans or adequate care plans addressing these illnesses. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurse, should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. In order for the Facility to make progress regarding this provision of the Settlement Agreement, the HMPs/Integrated Health Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ Be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized. Since the last review, the Facility had taken a positive step by beginning collaboration with other disciplines regarding the development of Integrated Health Care Plans so that an interdisciplinary team approach would be used consistently, and interventions from other disciplines would be integrated in all Health Care Plans as required by Sections G and F of the Settlement Agreement. In alignment with this collaboration, the Facility should continue to give thoughtful and serious consideration to how to incorporate an individual's health risks and specific interventions addressing the risks into one plan in alignment with the At-Risk system that clearly identifies the clinical needs of the individual. Overall, there had been little to no progress made addressing this provision of the Settlement Agreement. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent 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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. With regard to this provision, LBSSLC's Self-Assessment indicated the following actions were implemented: ▪ In August 2012, a review of training that took place between 5/7/12 and 5/15/12 indicated 99 of 99 nurses (100%) were instructed on implementation of nursing protocol cards, including eight agency nurses the Facility was using.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, in July 2012, protocol stickers were implemented, and on 8/6/12, nursing protocol audits were implemented to validate compliance. An initial audit conducted on 8/20/12 of a random sample of 18 (8.4%) individuals found that six of 18 records (33%) included the use of nursing protocol cards in some of the nursing documentation. Although there were a number of problematic methodology issues noted in the monitoring process described in the Self-Assessment for Section M, the initiation of audits of the nursing documentation in alignment with the nursing protocols was a positive step forward. ▪ The Facility's Self-Assessment indicated that at the time of the review, no data were available since the following systems were in the developmental stages: tracking and trend analysis for all nursing training; nurse educators use of the standardized competency-based checklists as set forth in the SSLC Nursing Education Handbook to provide competency-based training; documentation that demonstrates competency of nurses conducting training; assessment of the effectiveness of training through random walkthroughs, spot checks, and random competency skills checklists during actual assessments and procedures; and assessing nurses' knowledge of state and local facility policies, procedures, and protocols. Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because nurses are not yet documenting per the approved nursing protocols in their entirety to better address and identify health care problems and proper notifications and follow-ups are not consistently identifying the changes in status. In addition, further monitoring and guidelines are needed to ensure proper use and compliance." Although the Facility indicated that the nursing protocols had been implemented, the Monitoring Team found the same significant problematic issues regarding nursing assessments, care plans, and the overall nursing care and associated documentation as was found during previous reviews. As noted from the findings regarding nursing care plans discussed with regard to Section M.3, and the documentation of nursing care for individuals who were admitted to a community hospital detailed with regard to Section M.1, since the Monitoring Team's last review, nurses' understanding regarding the importance of nursing protocols had not improved. The concerns regarding the consistent problematic issues related to individuals with high-risk health indicators and changes in status warranting hospital admissions was confirmed during an onsite review of Individual #258's health issues. While on site, a review of Individual #258's medical record was conducted with some members of the nursing staff as well as members of the Facility's Physical and Nutritional	

#	Provision	Assessment of Status	Compliance
		Management Team. He was noted to be at high risk for aspiration, choking, constipation, dental issues, falls, fluid imbalance, fractures, GI concerns, osteoporosis, seizures, skin integrity, and urinary tract infections. In addition, he had a history of several episodes of aspiration pneumonia, as well as numerous emergency room visits and hospital admissions related to dehydration. He had been hospitalized three times for seizures, vomiting, and respiratory distress thus far this year. In reviewing the documentation for Individual #258, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ There was no recent Comprehensive Nursing Assessment found in the active record at the time of the review. ▪ The HMPs found in the Active Record addressing dehydration, constipation, skin integrity, risk for aspiration, potential for injury, and urinary tract infections were the basic template with little to no individualization for an individual with a significant number of health risks. ▪ None of the HMPs noted above were in alignment with nursing protocols. ▪ There were no HMPs found addressing his high-risk health indicators for dental issues, GI concerns, and seizures. ▪ The IPNs contained no consistent and regular nursing assessments to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, skin assessments, treatments provided, pain assessments, vital signs, oxygen saturations, bowel and urinary output, daily fluid input, assessments for hydration, bowel sounds and abdominal palpation. ▪ There were gaps in the nursing documentation indicating that nursing was not regularly checking and assessing an individual with several health risks and changes in status. ▪ There were missing trigger sheets for May, June, and August 2012. ▪ Since there were no nursing assessments regularly conducted, changes in status could not be quickly recognized and responded to. ▪ There was no indication that the physician was consistently notified of changes in status. ▪ There was no indication the PNMT was notified of changes in status. ▪ No IPNs were found indicating that Individual #258 was being followed, assessed, or regularly monitored by the PMNT, at the time changes in status occurred. ▪ There was no indication that the IRRF was reviewed/revised after changes in status and hospitalizations, since it was dated 10/4/11. Also, a review of an additional nine individuals that were admitted to the hospital since	

#	Provision	Assessment of Status	Compliance
		the last review (i.e., Individual #136, Individual #181, Individual #113, Individual #149, Individual #33, Individual #323, Individual #324, Individual #2, and Individual #90) found similar problematic issues throughout the nursing documentation as those found during Individual #258's onsite review (more detailed findings are provided with regard to Section M.1). These consistent problematic findings did not support that the Facility had actually implemented the use of nursing protocols. From the Monitoring Team's review, there was no indication that nursing was actually using nursing protocols as part of a structured system 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 care plans were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice accurately reflected quality standards by which to measure the Facility's nursing care, and documentation. Consistent with past reviews, the problematic findings from this review indicated that LBSSLC continued 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. This 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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In response to this requirement, LBSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ As noted in more detail with regard to Section I, revisions had been made to the At-Risk Individuals system. Some of the revisions included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, linking each risk factor with specific clinical indicators, and reformatting the Integrated Risk Rating Form to follow the same grouping sequence as the Risk Guidelines. In addition, the Risk Action Plans for the identified high and medium risk indicators were replaced with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually, supplemental forms regarding IRRF and the IHCP were developed addressing changes in status, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Aspiration Pneumonia Enteral Nutrition evaluation was revised to be used as a data collection tool rather than a format for assessment, and individual-specific Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. ▪ At the time of the review, the Facility had implemented the "Enhanced Risk Process" described above at Residences 504W and 514. Since the system had only been implemented recently at the time of the review, the Monitoring Team was not able to adequately assess any progress made from the system revisions. However, the Facility Self-Assessment contained no information or Action Plan addressing the problematic issues found from previous reviews regarding the Comprehensive Nursing Assessments and the health risk indicators. ▪ Overall, in addressing the elements and systems of this provision of the Settlement Agreement, the Facility's Self-Assessment indicated that the monitoring processes within the Nursing Department had been temporarily suspended due to changes in nursing administration and key leadership positions. Consequently, the Facility noted no data were available since systems addressing this provision were in the developmental stages. ▪ However, although not related to this provision, the Self-Assessment for Section M.5 contained actions taken related to issues regarding infection control that is discussed above with regard to Section M.1. The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because there in not a current system to readily identify, document, track and trend that the IDT is discussing plans and progress at integrated reviews as indicated by the health status changes of the individual." Consistent with past reviews, the findings from the Monitoring Team noted below indicated the quarterly and annual Comprehensive Nursing Assessments reviewed did not adequately address the risk issues. A review of records for 22 individuals determined to be at risk (i.e., Individual #283, Individual #51, and Individual #282 for dental issues; Individual #308, Individual #165, and Individual #298 for constipation; Individual #324, Individual #276, and Individual #160 for cardiac issues; Individual #74, Individual #235, Individual #94, and Individual #220 for weight issues; Individual #52, Individual #204, and Individual #232 for osteoporosis; Individual #136, Individual #164, and Individual #312 for fractures, Individual #183 for ear infections, Individual #178 for PICA, and Individual #1 dementia) found that none (0%) included adequate nursing risk assessments. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 22 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk	

#	Provision	Assessment of Status	Compliance
		health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted to have regressed from the previous review in that some of the nursing assessments did not reflect any clinical information regarding the health risk indicators, while others merely listed the generic interventions from the HMPs. As noted from the previous reviews, nursing had no specific procedure in place to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments for the At-Risk individuals were not adequate to address the health risks of the individuals reviewed. 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 in the Integrated Risk Rating forms. Although as noted with regard to Section I, the Monitoring Team found that there was overall more specific clinical information contained on the forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, a decrease in this individual-specific information was noted from the previous review. In addition, when reviewing some the Integrated Risk Rating forms for individuals who had changes in status, there were no revisions or updates to information found on the IRRFs. In addition, a review of the 22 records for these individuals determined to be at risk found 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 for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ 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%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage fluids or increase activity, which would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 14 of the cases (64%). Individuals who had	

#	Provision	Assessment of Status	Compliance
		not had their Risk Action Plans integrated into their ISPs included: Individual #282, Individual #308, Individual #165, Individual #298, Individual #324, Individual #160, Individual #52, and Individual #204. ▪ 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 the Monitoring Team's observations of two ISP meetings while on site and discussions with the Facility staff, the revisions to the At-Risk Individuals Policy and the recent pilot project initiated regarding the At-Risk process had promising potential. However, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans and HMPs still needed to be addressed. In addition, the Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. At the time of the review, the Facility indicated that they were not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In response to this requirement, LCSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ Of 78 Medication Administration observations conducted by the Nurse Educator from March through July 2012, the CNE reviewed 10 observations (13%). However, the Facility's Self-Assessment indicated that due to problems with the database, a trend analysis was not currently available. ▪ The Facility's Self-Assessment indicated that a review of medication observation tracking sheets from 4/1/12 to 6/30/12 indicated that 38 (76%) of 50 nurses who give medications routinely were being monitored as required. However,	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	there was no additional information found in the Self-Assessment indicating the causes for the low compliance score and what actions the Facility took to address this issue. ▪ In August, the Facility conducted a survey of all 15 residences and found that 100% of the residential buildings had a medication room as well as privacy screens to be utilized, if necessary. However, there was no additional information contained in the Self-Assessment indicating if the privacy screens were being appropriately used during medication administration. ▪ In addition, the Facility indicated that a review of data from 6/21/12 to 8/21/12 from the Medication Room Surveys found that they were being conducted on each home with immediate corrective actions taken. However, the Facility Self-Assessment did not include information regarding what problems were found and what corrective actions were taken. Also, the Facility indicated that tracking and trending for any problems noted on the surveys was needed in order to determine systemic issues. Regarding the Facility's compliance rating, the Self-Assessment stated: "based on this self-assessment, this provision is not in substantial compliance because the current method of monitoring does not capture the essential quality elements of medication administration and the data that is being collected is not yet being trended and analyzed systematically enough to develop efficient corrective action plans." In addition to the information that 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 indicated that since the last review, the Facility also had initiated the following steps regarding the Facility's overall medication administration system: ▪ In August 2012, the Facility implemented a very positive procedure that included requiring the nurses to bring the Medication Administration Records (MAR) to shift change for the off-going and on-coming nurse to review the MAR for blanks and/or omissions. Information contained in the Medication Safety and Systems Committee meeting minutes indicated that since this procedure was initiated, the number of MAR blanks was significantly decreasing. In addition, in September 2012, the Facility had developed a protocol addressing Weekly MAR Checks. ▪ In August 2012, the Facility began training staff regarding proper positioning and presentation during medication administration using the comprehensive state curriculum reviewed previously by the Monitoring Team. Initially, 32 nurses received the training. The Facility Self-Assessment indicated that this training had reinforced the use of the Physical Nutritional Management Plans	

#	Provision	Assessment of Status	Compliance
		during medication administration. ▪ Since the last review, from a total of 21 (N) medication variances with a severity score of "B" or above, the Clinical Pharmacist reviewed 11 (n) of these variances (52%), and scored the event the same as nursing in all (100%) the cases reviewed based on the information contained in the variance report. However, as discussed with regard to Section N.8, the Monitoring Team's review of a sample of these medication variance reports showed different results. ▪ During the last review, the Facility implemented a system to decrease medication variances related to medications being given to the wrong individual. The Facility implemented a pilot project at Residence 521. It included training of the direct support professionals regarding their responsibilities during medication administration in assisting the individuals and the nurse. Laminated identification cards with each individual's picture on them were created for the direct support professionals 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. The Facility indicated that 28 (100%) of 28 audits for data reviewed from 7/2/12 to 8/15/12, concerning the use of the ID card indicated that 100% of the individuals were properly identified 100% of the time with this new system. This was a very positive step forward in the prevention of medication variances that involved administering the wrong medications to an individual. The Facility indicated that this system would be expanded to 504 East and West by October 2012, and then Facility-wide. ▪ The Provision Action Information report indicated that the Residential Services Director had implemented a process that included the monitoring of two medication administrations each month by the Residential Coordinators to ensure that direct support professionals and nursing were working together during medication passes. ▪ Although none had been reported yet, an interview with the Clinical Pharmacist indicated that the Facility was now including any pharmacy and medical variances in the Facility's data. Clearly, the steps forward discussed above included some very promising, and thoughtful interventions. It was positive the Facility had initiated these activities to address a number of elements of the medication administration system. However, at the time of the review, 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, observations from the Monitoring Team while on site, and discussions	

#	Provision	Assessment of Status	Compliance
		with Nursing Department staff, the following were some of the problematic issues identified: ▪ The Facility reported that the percent compliance from the Medication Administration Observations conducted was found to be consistently between 93% and 100%. However given that the Facility's data showed that 4,062 unexplained medications were returned to the pharmacy from April 2012 through August 2012, the Medication Administration Observation data was highly questionable. There was no indication that nursing was analyzing these obvious discrepancies in data. ▪ Although Pharmacy and Nursing had been focusing significant energy on reviewing a number of the systems related to the Facility's medication administration system, the Facility continued to have problematic issues regarding the number of unexplained medications that were being returned to the Pharmacy each month, indicating a number of dosages potentially were not being given as ordered. From the Monitoring Team's observations during the Medication Safety and Systems Committee meeting while on site, it had been noted that there had been a number of Miralax doses, a laxative, returned to the Pharmacy. However, when the Nurse Operation Officer was asked if there had been any increase in the episodes of constipation and thus an increase in the use of PRN medications for constipation for the residences that were found to have unexplained dosages returned to the Pharmacy, she responded there were no problems noted without supporting data to validate this issue and ensure that the individuals potentially affected had not experienced any changes in status. ▪ At the time of the review, there had been no formal tracking system implemented addressing the type of medications that were being returned to the pharmacy in order to identify emerging clinical issues with possible trends of unexplained returned medications. For example, if seizure medications were being returned in large numbers, the Facility should have determined if a trend was occurring with increases in seizure activity. ▪ The lack of consistent nurses assigned to specific residences and the use of Agency nurses due to staffing issues, such as vacant nursing positions or leaves of absences had been repeatedly identified by the Facility during past reviews as a factor resulting in increases in medication variances. However, there was no indication that a plan or procedure was developed and implemented addressing these situations, especially in light of the recent staffing challenges the Nursing Department had experienced. ▪ Although the Facility was spending much time reconciling the 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.	

#	Provision	Assessment of Status	Compliance
		▪ In addition, from discussions with the CNE, to determine a passing or failing grade for 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, during past reviews, the Monitoring Team had indicated that 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. At the time of the review, the Facility had a draft of the Medication Administration Observation tool that included assigned weights for each item. Instead, the Facility in conjunction with the State should consider identifying critical elements of the medication administration procedure that if not completed appropriately would result in a failed observation rather than trying to assign weight to each of the items. The weighting of such a tool would usually involve a lengthy and involved systematic process, which was not necessary to achieve the desired result. A review of the medication variances reported by the Facility indicated the following: ▪ April 2012 - 12 variances and 398 unexplained returned medications; ▪ May 2012 - 24 variances and 930 unexplained returned medications; ▪ June 2012 - 17 variances and 977 unexplained returned medications; ▪ July 2012 - 21 variances and 734 unexplained returned medications; and ▪ August 2012 - 62 variances and 1003 unexplained returned medication. Based on observations of medication administration at Sparrow, the following problematic issues were found. Specifically, the nurse did not: ▪ Know the correct position for the individual during medication administration. Although the nurse reviewed the PNMP before administering the medications, she was not able to identify the correct position the individual should be in before administering the medications; ▪ Seem familiar with the use of a G-Tube. While administering medications, she left the lever opened twice, which allowed the medication to run out of the tube; ▪ Direct the direct support professionals regarding the position to maintain after the medication was administered; ▪ Provide education to the individual regarding the medications that he was receiving; and ▪ Evaluate lung sounds after medication administration until prompted by the	

#	Provision	Assessment of Status	Compliance
		Nurse Educator. However, on a very positive note, the medication administration observation conducted by the Monitoring Team at Quail found that all the elements of medication administration were accurately and appropriately executed including: ▪ Proper identification of the individual prior to medication administration; ▪ Lungs sound assessed before and after medications were administered; ▪ PNMP reviewed and proper positioning ensured prior to administering the medication; ▪ Privacy provided; ▪ Placement of G-Tube checked; and ▪ Education provided to the individual regarding the medications being administered. 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 and implement strategies addressing a number of the problematic elements of the medication administration system. 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. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

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

1. As previously recommended, the Facility 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. 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 any new positions. (Section M.1)
3. The Facility should continue to implement and expand the use of nursing protocols to guide nursing practices. In conjunction with the continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the expanded use of the protocols. (Section M.1)
4. As noted in past reports, due to the number of individuals with complex medical needs at LBSSLC, this area should be considered a priority for

Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. (Section M.1)

5. The Facility should 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. (Section M.1)
6. The Facility should consider aggregating and analyzing the data from the "Real Time" Infection Control audits, along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. (Section M.1)
7. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. (Section M.1)
8. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)
9. Although in its comments the State consistently has indicated that it makes infection control experts available to the Facilities, given that this was not evident from LBSSLC's infection control program discussed in Section M.1, consideration should be given to having additional expertise and/or a different type of technical assistance in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control Systems in alignment with IC standards of practice and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
10. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement to check the emergency equipment. (Section M.1)
11. 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. (Section M.2)
12. It is crucial that LBSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
13. The Facility should develop and implement appropriate care plans based on priority, and risk for all the individuals at LBSSLC. (Section M.3)
14. Nursing Administration, in conjunction with the Infection Control Nurse, should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
15. Although in its comments on the draft report, the State asserts it has defined an adequate process for nursing's assessment of at-risk individuals, as discussed with regard to Section M.5, this was not evident from the resulting quarterly or annual nursing assessments. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. If Facility and/or State staff do not have the expertise to adequately define this process and/or provide the necessary training and mentoring, the State should engage consultants that can provide the necessary expertise. (Section M.5)
16. 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 plans of actions aimed at long-term resolutions. (Section M.6)
17. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, and reconcile discrepancies regarding the actual variances that have occurred. (Section M.6)
18. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a thoughtful and critical review of the overall medication system. (Section M.6)
19. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to

making compliance determinations. (Facility Self-Assessment)

20. Since there had been significant turnover in many of the nursing positions, the Facility will need to address processes regarding establishing inter-rater reliability for each of the monitoring tools. (Facility Self-Assessment)
21. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. (Facility-Self Assessment)
22. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reason for any data/findings discrepancies. (Facility Self-Assessment)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All DUE reports completed since the Monitoring Team's last visit, including 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 Minutes of Pharmacy and Therapeutics Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including specification if fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, for all individuals the Facility services, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one year period (beginning 1/1/12); o For Quarterly Drug Regimen Reviews two most recent per residential home that have been completed with physician signatures and dates, including for anti-cholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy, including those for: Individual #313 8/2/12, Individual #76 6/28/12, Individual #213 7/3/12, Individual #7 7/3/12, Individual #209 6/28/12, Individual #43 8/2/12, Individual #181 7/30/12, Individual #299 8/6/12, Individual #35 8/2/12, Individual #210 7/2/12, Individual #314 6/27/12, Individual #179 5/24/12, Individual #237 5/29/12, Individual #176 7/30/12, Individual #79 5/30/12, Individual #73 5/24/12, Individual #290 7/2/12, Individual #114 6/27/12, Individual #232 5/24/12, Individual #124 7/3/12, Individual #221 5/29/12, Individual #13 5/30/12, Individual #191 7/30/12, Individual #143 5/24/12, Individual #106 7/3/12, Individual #139 7/30/12, Individual #25 5/29/12, Individual #4 5/29/12, Individual #58 8/6/12, and Individual #315 8/2/12; 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, including those for: Individual #313 8/2/12, Individual #126 4/6/12, Individual #100 7/2/12, Individual #20 3/1/12, Individual #220 7/3/12, Individual #73 5/24/12, Individual #282 6/28/12, Individual #137 6/27/12, Individual #132 8/2/12, and Individual #223 4/2/12; o All "single patient intervention reports" in WORx system since the Monitoring Team's last visit; 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 reports (ADR) 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, home, shift, unit, individual, category of severity, error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between pharmacy and Nursing Department concerning medication errors/variance (emails, memos, etc.) since the Monitoring Team's last visit; 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 months for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when Quarterly Drug Regimen Reviews 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 rated as being at medium risk for polypharmacy; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #36 4/30/12, Individual #7 4/30/12, Individual #299 6/9/12 0840hr, Individual #299 6/9/12 1101hr, Individual #299 6/10/12 0844hr, Individual #299 6/11/12 1140hr, Individual #299 7/18/12 1037hr, Individual #82 7/15/12, Individual #322 3/22/12, Individual #124 4/24/12, Individual #320 4/2/12, Individual #25 3/11/12, Individual #288 3/5/12, and Individual #315 7/23/12; o Any trend analysis of chemical restraint use (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 For 10 orders involving drug-drug interactions, copies of serial computer screen shots for

	each step. Submitted documents were for the following 10 individuals: Individual #258, Individual #27, Individual #15, Individual #179, Individual #176, Individual #304, Individual #104, Individual #8, Individual #167, and Individual #89; o For four orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. Submitted documents were for the following four individuals: Individual #309, Individual #114, Individual #197, and Individual #75; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. Submitted documents were for the following five individuals: Individual #146, Individual #257, Individual #239 (two orders 3/26/12, 7/18/12), Individual #273, and Individual #288; o For five new orders in which labs are reviewed/monitored, copies of serial computer screen shots for each step. Submitted documents were for the following five individuals: Individual #171, Individual #167, Individual #106, Individual #182, and Individual #288; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/information provided to PCP and response of PCP. Submitted documents were for the following four individuals: Individual #176, Individual #40 (two new orders for 7/26/12), Individual #167, and Individual #198; and o For Presentation Book for Section N. ▪ **Interviews with**: o Billy Bob Beck, Pharmacy Director; and o John Todd, RPh, Clinical Pharmacist.
	Facility Self-Assessment: For Section N, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The Pharmacy Department at LBSSLC developed the monitoring/audit tools the Facility used to conduct its self-assessment. These included: monitoring tool for new orders (drug-drug interactions, laboratory monitoring, allergy history, dosage range, and side effect profile, PCP follow up) for Provision N.1; QDRR monitoring tool (tracking of compliance with due dates from pharmacy, QDRR content) for Provisions N.2, and N.3; QDRR monitoring tool for Provision N.4 (tracking of compliance with due dates for PCPs and psychiatry); and audit of medication variance severity categorization (July 2012). Concerning other QA monitoring of the Pharmacy Department, the QA Department completed the March 2012 review of the State Monitoring Tool for the Settlement Agreement. At that time, the QA Department found some areas of concern with new orders and medication variances. Since that time, the Pharmacy Department created its own tools to measure these subsections, and did not use the State Monitoring Tool for the Settlement Agreement. Information submitted from the QA Department indicated there was no monitoring of pharmacy services from April through July 2012, although the pharmacy indicated that specific tools were monitored from May 2012 for data from

	March 2012. o These monitoring/audit tools included many important indicators to allow the Facility to determine compliance with the Settlement Agreement. However, some sections lacked adequate indicators. For example, Section N.3 includes a number of specific requirements for QDRRs, but the Facility's Self-Assessment did not address all of them. It simply referenced: "the appropriate data elements." This did not adequately break out the various requirements. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as review of data in WORx, physician follow-through orders, applicable laboratory data, and QDRR document review. o The Self-Assessment identified the sample(s) sizes. However, not all included the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For example, a sample size of 10 QDRRs was selected for each of the months from September 2011 through July 2012, but the total number of QDRRs completed over the course of these months was not stated. Although these sample size(s) generally appeared to be adequate to consider them representative samples, this was difficult to confirm without knowing the total number of the population size. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Clinical Pharmacist, and Pharmacy Director. o The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools, because the QA component of monitoring had been suspended after March 2012, and was to resume in August. No QA data was available after March 2012. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement are being reached. These included the WORx database of patient interventions (new orders for drug-drug interactions, significant side effects, allergies, appropriate dosage, and laboratory monitoring interventions), QDRR tracking database, chemical restraint database, adverse drug reaction reports, training logs for in-services on adverse drug reactions, database of medication variance reports, tracking system and corrective action plans for medication variance analysis, and database for unexplained returned medications. The quality of the data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources that were not considered included monitoring completed pharmacy reviews for chemical restraint forms. The Facility had identified this as an issue that needed to be corrected. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's

	Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following subsections of Section N: N.1, N.2, N.4, N.5, and N.7. This was consistent with the Monitoring Team's findings, with the exception that, with the most recent training information available, the Facility was compliant with Section N.6. ▪ The Facility data identified areas of need/improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying, for example, the need to review the routing of the chemical restraint documentation, and the need to further review the unexplained returned medication.
	Summary of Monitor's Assessment: The Pharmacy Department had been diligent in reviewing new orders in the several areas outlined by the Settlement Agreement (e.g., significant side effects, drug-drug interactions, appropriate dosage, laboratory monitoring, and allergies). Quarterly drug regimen reviews provided a review of a number of aspects of the medications prescribed to individuals, and the Facility was consistently completing these reviews. Training of staff concerning identification and reporting of adverse drug reactions had recently been completed. Drug utilizations appeared to continue to be completed in a timely manner. The Pharmacy Department also created a number of internal monitoring tools that were helpful to the department in ensuring compliance and identifying areas of need. Areas of need included tracking and monitoring timely completion of the pharmacy section of chemical restraint forms. A statement of effectiveness or not of the chemical restraint would provide additional guidance to the IDT. The Pharmacy Department had collaborated with the Nursing Department in resolving the challenge of medication variances. There has been progress in resolving documentation errors related to medication administration. The number of unexplained medications returned remained a concern, but the Pharmacy Department was involved with additional pilot programs to address this challenge. Over the past two years, the Pharmacy Department had been involved in several projects to resolve medication variances, but these efforts and their outcomes had not been summarized in timeline fashion. This would allow a historical perspective of gains made in this area, as well as areas still requiring attention.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's	A submitted document listed licensed pharmacy personnel. Listed were two certified pharmacy technicians, and, specifically, one registered pharmacist. There were three other names listed with licenses through the state board of pharmacy, two of whom were registered pharmacists. The license/title of the third personnel was not submitted. The Pharmacy Department submitted copies of updated policies/procedures/protocols.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	These included what appeared to be a draft of the "LBSSLC – Health Services: Pharmacy Services," dated 5/14/12 (R). There were a number of crossed out sections and new entries underlined. It was not clear whether this had been finalized. Additionally, there were three attachments that appeared to be complete or unaltered: Exhibit A: Procedures; Exhibit B: Required Facility Procedures; and Exhibit C: Identifying Unusable Drugs. Additionally, a form "LBSSLC: Found Medication Report" was attached. It was not clear if these last four documents were in the process of revision. The Pharmacy Department completed no state/federal regulatory surveys since the Monitoring Team's last visit. The Pharmacy Department utilized several QA tools created in the department rather than the revised "Texas Health Monitoring Instrument: Pharmacy Services and Safe Medication Practices" audit tool, in order to monitor its activities. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review. The following lists the number of patient intervention entries generated per month: March 19 to 31, 2012 – 72, April 2012 - 150, May 2012 – 132, June 2012 – 134, July 2012 – 132, and August 1 to 13, 2012 - 20. The total number of patient interventions from March 19, 2012 through August 13, 2012 was 640. These were subcategorized. There were 152 categorized as adverse drug reaction interventions, five categorized as allergy/disease state contraindications, 111 categorized as drug information, 332 categorized as therapeutic consultation, and four categorized as patient care. It is recommended that all entries in the "Patient Intervention" entries in WORx include the name of the medication and dosage/frequency. A sample of 30 new prescriptions was reviewed. These were reviewed to determine whether a screenshot confirmed the new order (or as an alternative, a copy of the PCP order was submitted), there was a patient intervention report documenting the medication and dosage of concern and the communication with the PCP, and if there was a change in order, this was documented. For orders in which the PCP changed a dosage or timing based on the communication, evidence submitted also should have included this communication (i.e., copy of a new order and an order to discontinue the old order, or a new snapshot reflecting the new order and discontinuation of the old). These were considered essential components in ensuring the Pharmacy Department monitored the new order through to completion. Additional information (e.g., handouts provided, etc.) was provided, depending on the type of order, for descriptive purposes, but was not considered an essential component. The following summarize the results: ▪ 10 new orders were submitted in which the pharmacy found concerns with	

#	Provision	Assessment of Status	Compliance
		drug-drug interactions with the current drug regimen. A computer screen shot of the order was submitted for 10 of 10 (100%). For 10 of 10 (100%), a copy of the patient intervention form was submitted. A handout was provided to the PCP in none of 10 (0%). A change in the medication ordered occurred in no orders. For six, there was to be increased monitoring or change in time of medication administration. Evidence for increased monitoring or changes in time were provided in six of six (100%). ▪ Four new orders were submitted in which **allergies** were reviewed and determined by the pharmacy to be a concern. A computer screen shot of the order was submitted for four of four (100%). A copy of the patient intervention was submitted in four of four. As a result of the pharmacy review, there was a change in order for two of four orders. There was confirmatory documentation of no change for two of four orders. There was evidence of the order change to verify the communication in two of two order changes. Based on this information, adequate documentation of the new order process for allergies occurred in four of four (100%) of submitted cases. ▪ Five new orders were submitted in which significant **side effects** were reviewed by pharmacy and determined to be a concern. A screen shot or new physician order was submitted in five of five (100%). A patient intervention note was submitted for five of five (100%). In summary, for these five orders submitted, 100% had adequate documentation concerning side effect review/collaboration with the PCP. Additionally, for one of five, the drug dosage was documented on the patient intervention note. From the submitted documentation, dosage could not be determined for four of five medications. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by pharmacy during initial review. A copy of the screen shot or copy of new physician order was submitted in five of five (100%). A copy of the patient intervention was submitted in five of five. New orders were written for five of five medications based on the communication with the PCP (i.e., all orders were changed). Evidence of the new change in order was submitted in five of five (100%). Lab data was submitted in five of five. Documentation was adequate in five of five (100%). ▪ Six new orders were submitted in which pharmacy had concerns about the potential need for **dosage adjustments**. For six of six orders (100%), there was a copy of the screen shot order submitted. A copy of the patient intervention was submitted for this in six of six orders (100%). The pharmacy forwarded a "PCP Communication Form" (an LBSSLC document) in four of six (67%). A change of order based on pharmacy review and PCP contact occurred in none of six. In summary, there was adequate documentation of the process in six of six (100%).	

#	Provision	Assessment of Status	Compliance
		The Pharmacy Department completed an internal QA review of the new order process. To standardize the process, the Pharmacy Department had developed monitoring instructions for Section N.1. Monthly activities included the following: ▪ Reviewing drug interaction interventions recorded in WORx. ▪ Reviewing other interventions recorded in WORx, such as a drug allergy to an ordered medication. If the intervention required a PCP decision or action, determining whether a PCP Communication form was initiated, reviewed by the PCP, and in response to the event/information, the PCP gave instructions. ▪ Reviewing all laboratory interventions documented in WORx. ▪ Reviewing to ensure dosage range was checked for all interventions. ▪ Updating the spreadsheet that reflects the interventions performed each month. This monitoring tool was updated on 3/5/12 to include the review of appropriate dosing of medication. Additionally, the WORx software allowed several subcategories to define the patient interventions. The Pharmacy Department created a "WORx Intervention Category Guide: Guide to Proper Categorization of Interventions" that listed the five subcategories to be used, and a brief descriptor of each subcategory. It also listed the categories in the drop down box that would not be used. This updated guide was dated 6/13/12. The monitoring tool monthly results were submitted. Although the Monitoring Team did not use the Facility's monitoring results in its assessment of compliance, it was positive that the Facility was conducting this self-assessment, and the results are included here for information purposes only. Monitoring by the Pharmacy Department from April 2012 through August 2012 indicated 100% compliance in drug interaction interventions, allergy/disease state contraindications, laboratory interventions, therapeutic consultations (dose range), side effect notifications and miscellaneous other interventions (added to the monthly report as of May 2012) when the sample included the subcategory. The QA Department also used this monitoring tool to review 10 new drug orders. Although it was not determined when QA began to utilize this tool or if this was done monthly/quarterly, etc., there was 100% agreement between QA and Pharmacy Departments for July 2012 (completed in August 2012), and for August 2012 (completed in September 2012). Separately, the 10/2/12 minutes of Pharmacy and Therapeutics Committee included a summary table entitled "Intervention Tracking – Pharmacy Services Fiscal Year 2012 for Monitor: N.1." This was a tabulation per month of the various categories of pharmacy communications for drug interaction. The following includes these categories listed, along with the number of interventions from March 2012 through August 2012: drug interaction - 208, laboratory monitoring -126, drug allergy - five, dosage range - 48, side	

#	Provision	Assessment of Status	Compliance
		effect notifications - 322, and other interventions - 14. Based on the Monitoring Team's review of new order documentation, the Facility remained in compliance with this provision.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A 2012 calendar for quarterly drug regimen reviews was submitted. For each month, residences were scheduled for review of the prior three months. During each three-month cycle, all residences would be reviewed. This was repeated quarterly throughout the year. A schedule of completed QDRRs was submitted from August 2011 through August 2012. For the last two calendar quarters, each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR's date of completion. A total of 226 of 228 had current QDRRs (99%) that were completed within the period of time from seven days prior to the due date of the QDRR to 14 days (through the 13th day) after the 90-day due date. This acceptable time period between QDRRs was between 83 and 103 days. For two individuals, the QDRRs were completed 107 and 111 days apart, which exceeded the allowed time period. There were three individuals for whom the most recent two QDRRs were less than 83 days apart, but this was due to moving between buildings, and the need to synchronize with the dates of QDRR completion in the new homes. A sample of 30 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 30 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for 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). ▪ All 30 QDRRs (100%) recorded each lab with dates the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab for 27 of 27 applicable QDRRs (100%). Three QDRRs did not have any abnormal labs. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Facility remained in compliance with this provision.	Substantial Compliance
N3	Commencing within six months of	This provision of the Settlement Agreement encompasses a number of requirements.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 new 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 14 chemical restraints used from 3/5/12 to 7/23/12. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that 10 individuals had 14 chemical restraints during this time period. This was consistent with a series of other reports, "All Chemical Restraints LSSLC" (Report date: 1/1/12 to 3/31/12, 4/1/12 to 4/30/12, and 5/1/12 to 5/31/12), "LBSSLC Chemical Restraint Report" (6/1/12 to 8/29/12). For the 14 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 14 chemical restraint forms, 13 forms (93%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in 10 out of the 14 chemical restraint forms completed (71%). ▪ Side effects and adverse effects were noted in 13 of the completed chemical restraint forms (93%). ▪ There was a review of the drug-drug interaction between the chemical restraint and the routine medication regimen of the individual in none of 14 (0%). ▪ There were 13 statements that were considered recommendations. There were nine recommendations for the IDT to review the events and develop an ISPA or BSPA based on findings. One indicated need for training, and two recommended changes in medication. ▪ The range of time for completion of the forms after the chemical restraint was given was from one to 72 days. Seven were completed within one to four days, five were completed within five to 10 days, and two were completed in greater than 10 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 14 completed, there were 14 forms (100%) on which the psychiatry comment section was completed. ▪ For 14 of 14 (100%), clinical justification was documented.	

#	Provision	Assessment of Status	Compliance
		▪ Side effect review occurred in 14 of 14 (100%). ▪ Effectiveness was documented in 12 of 14 of the cases (86%). ▪ Information discussing the risks of drug-drug interactions, or other risks was addressed in none of the 14 (0%). ▪ There were 10 recommendations documented. There was notation from review of the documents that Individual #299 was also ordered a chemical restraint on 7/17/12 at 0905hr, but according to the PCP order, this was not administered. As confirmation, a document entitled "LbSSLC Chemical Restraint Report" for report date 6/1/12 through 8/31/12, did not indicate the existence of this 7/17/12 restraint. Additionally, it was noted that one of the chemical restraints was for a medical reason (post–operative care). Information submitted did not include the IDT meeting prior to the surgery to predict the need for medication to improve cooperation, but post operative planning should include the goal of minimizing the use of emergency orders for chemical restraints. The other chemical restraints listed were due to behavioral issues. The Pharmacy Department also submitted a list of chemical restraints tracked through the Psychology Department as well as tracked through the Pharmacy Department. There were 37 chemical restraints recorded in each database for the time period September 2011 through August 2012. As internal tracking for chemical restraint use, the Pharmacy Department reviewed the provider morning meeting minutes and PCP orders received for evidence of chemical restraint use. If there was no restraint form received within three business days, then the Pharmacy Department was to contact the psychology department for verification/clarification. The Pharmacy Department also received a report each month, on the 10th of the month, which listed all chemical restraint use from the prior month. This was then matched with the list recorded in the Pharmacy Department. If there were discrepancies, the Psychology Department was to be contacted. <u>Polypharmacy</u> Of the 30 QDRRs reviewed, polypharmacy was noted in 23 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 23 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 23 (100%). ▪ Potential side effect risk was reviewed in 23 (100%) ▪ For 23 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. Polypharmacy also was reviewed through a monthly review of polypharmacy psychoactive medications at the Psychotherapeutic Polypharmacy Committee, and a	

#	Provision	Assessment of Status	Compliance
		summary of results was presented at the P&T Committee meetings. At the June 27, 2012 P&T Committee meeting, the psychiatrist reviewed the results of the fiscal year-to-date 2012 data. Of 126 individuals on psychoactive medications in May 2012, there were nine individuals with greater than one year of residence at the Facility with active polypharmacy, and 18 individuals considered to have stable polypharmacy. There were three individuals with residence of less than one year at the Facility that had polypharmacy. At the October 2, 2012 P&T Committee meeting, the psychiatrist reviewed the results of the prior quarter, and a graph was presented, but a table providing exact numbers of individuals in each of the categories was not provided. However, the data appeared to be similar, according to the graph. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 13 of the 30 QDRRs. ▪ Of these, 13 (100%) documented justification with appropriate diagnoses; and ▪ 13 QDRRs (100%) indicated whether side effects or other adverse risks were present. <u>Anti-cholinergic Monitoring</u> Of the 30 QDRRs, 30 (100%) were screened for medications associated with potential significant anti-cholinergic side effects. Nine QDRRs identified anti-cholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anti-cholinergic section of the QDRR was completed in nine of nine (100%) of cases with medication associated with anti-cholinergic side effects; ▪ Nine of nine (100%) documented clinical justification of the use of each of the medications contributing to anti-cholinergic load/effect. The clinical burden of the side effects was less than the benefit. ▪ Nine of nine (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 30 QDRRs reviewed, 10 listed atypical antipsychotic medication. Of these, 10 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). The pharmacy completed a monthly internal audit for Sections N.2 and N.3. Monitoring instructions were created for consistency of interpretation of findings. Seven areas were reviewed paralleling the different aspects of the QDRR. The sample size was 10 QDRRs randomly chosen from one home monthly after the QDRRs were completed. Each month, a summary report was completed. These were submitted. Again, the Monitoring Team provides information about the results of this for informational purposes only, and these findings do not impact the Monitoring Team's independent review. Ten indicators were chosen, with specific criteria for evidence. Indicators included the following: "Each drug	

#	Provision	Assessment of Status	Compliance
		ordered for psychiatric use has an indication on the QDRR," "Resident takes an atypical antipsychotic agent," "Laboratory monitoring for the atypical agent is present and being monitored," "Resident takes a drug for which serum levels are routinely monitored." "Drug serum levels monitored," "Resident takes a benzodiazepine," " Benzodiazepine monitoring is done (clinical justification and side effects)," " poly-pharmacy and clinical justification for use," "anti-cholinergics (side effects and clinical justification)," and a general category: "low/high lab results noted on QDRR if applicable." Summary reports for March through July 2012 were submitted. All indicated 100% compliance for all 10 indicators. The September data was submitted through the October 2, 2012 Pharmacy and Therapeutics Committee meeting. Beginning July 2012, the QA Department began to review the QDRRs with this monitoring tool to determine inter-rater reliability. As an example of the activity, a document was submitted entitled "QDRR Quality Monitors – N.2/N.3-Inter rater" for September 2012. The document indicated the QA and Pharmacy Department completed a review on the same day (9/18/12) for 10 individuals. All scores were 100%, indicating inter-rater reliability of this monitoring tool. Although progress continued to be noted, the Facility remained out of compliance. The area that continued to require improvement was the Pharmacy and Psychiatry's timely review and complete review of chemical restraints. In offering a comment or recommendation, the Pharmacy Department should include whether the chemical restraint was effective and whether the pharmacy is recommending the same dose for future needs, or whether the medication, dosage of medication, or route of medication should be reviewed. Additionally, there should be information concerning any significant potential drug-drug interaction with the individual's current medication regimen.	
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. ▪ There was one formal recommendation and two additional comments that were recommendations from the 30 QDRRs. ▪ Evidence of PCP review of recommendations and agreement was noted in 30 of 30 (100%) of QDRRs. o There was disagreement by the PCP for no QDRR. o The PCP responded within 14 days of the QDRR being completed by pharmacy in 30 of 30 QDRRs (100%). ▪ Psychiatry was required to review the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 19 of 30 QDRRs, because these were the ones in which psychotropic polypharmacy was an issue. ▪ Agreement was documented in 19 of 19 (100%). ▪ Disagreement with found with none, so justification was not necessary. ▪ The psychiatrist responded within 14 days of the QDRR being completed by	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		pharmacy in 19 of 19 QDRRs (100%). To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility was requested to submit 10 active records in which recommendations from the QDRR were not followed. The pharmacy indicated: "there were no recommendations made that were not accepted." In its comments to the draft report, the State/Facility asserted that the Monitoring Team reversed the following two paragraphs and that: "Paragraph 3 should begin... 'The QA Department initiated....' And (sic) Paragraph 4 should begin.... 'The Pharmacy also monitored Section N4' etc." The Monitoring Team reviewed the documentation again, and the State/Facility's assertion is not substantiated through the documentation it provided. Some changes have been made to the following paragraphs to attempt to provide further information to the State/Facility about the documentation it submitted for the Monitoring Team's review. The Pharmacy Department initiated an internal monitoring tool for Section N.4 in May 2012 for the March 2012 data. Monitoring instructions provided guidance through a series of 17 steps to ensure the QDRR was routed from the pharmacy, to the PCP, psychiatrist, and back to pharmacy in a timely manner, along with the steps to be completed by each professional. These updated instructions were developed on 3/5/12. All QDRRs per month were reviewed using this process (66 QDRRs reviewed in March 2012, 78 QDRRs reviewed in April 2012, 75 QDRRs reviewed in May 2012, 66 QDRRs reviewed in June 2012, 77 QDRRs in July 2012, and 72 QDRRs reviewed in August 2012). Monthly summaries were created, and these were submitted for the months of March 2012 through August 2012. For all months submitted, compliance was 100%. (Again, this data is presented for informational purposes only.) Included in each monthly summary was the number of QDRRs completed, whether the PCP signature and date was found, whether the PCP checked the box for agreement or not of recommendations, whether the psychiatrist signed and dated the form if indicated, and whether the psychiatrist agreed with the recommendations or not. Additional internal pharmacy monitoring occurred starting June 2012, and reviewed timeliness of completion by the pharmacist, the PCPs, and the psychiatrists. Compliance was calculated for timeliness of pharmacy reviews within the 90-day time period. Compliance was also calculated for PCP and psychiatry completion (when appropriate) within 14 days of receipt. The Facility's data showed compliance was 100% for June	

#	Provision	Assessment of Status	Compliance
		through August 2012. The QA Department also monitored Section N.4. Based on the Facility's QA data, there was 100% compliance for applicable questions numbered one through 11, for the monthly reports submitted (May to August 2012 for data collections of March to May 2012). These were the same questions used to complete the monthly internal pharmacy review (i.e., dates of completion of QDRR by pharmacy, prior QDRR completion date, date of PCP signature, etc.). Agreement or not by the PCP/psychiatrist concerning the recommendations also was tracked. The QA Department reviewed two to three QDRRs per home (a 20% sample) and determined there was 100% compliance for the questions asked. However, they commented in the May 2012 review on the long delays in completing the process. Fifty to 62 days was average length of time between QDRR completion to routing to the PCP, psychiatrist, and back to the pharmacy followed by filing. The QA Department appeared to review timeliness of the process, but this aspect did not appear to be captured in the first set of monitoring indicators from the internal pharmacy reviews. However, it was included in the internal pharmacy monitoring reviews that started June 2012. Improvement in timely completion improved in June 2012, and was not mentioned as a concern in the July or August 2012 reviews the QA Department completed. Based on the Monitoring Team's review of related QDRR documentation, the Facility remained in compliance with this provision.	
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.	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 Dyskinesia Identification System: Condensed User Scale (DISCUS), and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale (MOSES) 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 prescribing practitioner reviewed and signed the documentation. The Director of Psychiatry indicated that the nursing staff performed the MOSES evaluations, and the Psychiatry Assistant performed the DISCUS examinations. As noted in previous reports, the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all of the 19 individuals (100%).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The records of the 19 individuals contained documentation that the prescribing practitioner had reviewed the MOSES evaluation in a timely manner (within 14 calendar days) for all of these individuals (100%). 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 indicated the DISCUS was current, and had been performed quarterly for the past year for all but one individual (date of most recent DISCUS evaluation): Individual #82 (most recent DISCUS was dated 6/6/12). Thus, the DISCUS had been performed as specified for 18 of the 19 individuals (95%). The prescribing practitioner had signed all of the completed DISCUS evaluations in the sample records within 14 calendar days of completion (100%). The specific information for the individual for whom a problem was noted has 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. Although Reglan is prescribed for gastroesophageal reflux disease (GERD), it has pharmacological properties that are similar to those of antipsychotic agents. The Psychiatry Assistant also performed the DISCUS for those individuals prescribed 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 (23% of the 22 individuals fitting the above criteria) was selected: Individual #323, Individual #136, Individual #199, Individual #74, and Individual #176. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for four of these individuals (80%). The missing documentation was for Individual #199, for whom no documentation of a MOSES evaluation could be found prior to the 7/9/12 evaluation. The only individual in this sample for whom the documentation had not been signed in a timely manner was Individual #176 (80%) for whom there was a gap from 1/3/12 to 1/20/12 before the prescriber's review was performed. 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	

#	Provision	Assessment of Status	Compliance
		completed as specified for all five of the individuals (100%). The prescribing practitioner also had uniformly reviewed and signed these evaluations in a timely manner for all of these individuals in the sample (100%). The review of the overall completion rate of the MOSES every six months, as specified in the Settlement Agreement, indicated that these evaluations had been carried out as specified for 23 of the 24 individuals in the overall sample of 19 individuals receiving psychotropic medication and five prescribed Reglan (96%). The assessment of the timely review of these documents by the prescriber indicated that the review had been completed within 14 days for 23 of the 24 individuals (96%). A similar analysis of the assessments with the DISCUS every three months indicated that they had been performed as specified for 23 of the 24 individuals in the combined sample (96%). The corresponding analysis of the timely signature of these documents was 100%. These uniformly high rates of completion indicated the Facility had developed a system to routinely ensure side effect monitoring tools were completed, as specified in the Settlement Agreement. This resulted in the finding of substantial compliance for this provision.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	Training of adverse drug reactions included an initial mandatory training, as well as a training schedule for new hires. Training content included in-service education on the following documents for Medical, Psychiatry, Pharmacy, and Nursing Departments: LBSSLC Policy – Health Services: Adverse Drug Reaction Reporting, dated 7/22/11, Adverse Drug Reaction Reporting Form, and Adverse Drug Reaction Reporting training handout (training provided by Pharmacy Department). Training content included in-service education on the following course for Nursing Departments and direct support professionals: Observing and Reporting Clinical Indicators of Health Status Change. The course was first provided as a mandatory in-service to direct support professionals and nurses, following which it was incorporated into the new employee orientation training. The Nursing Education staff taught this. From August 1, 2011 through September 25, 2012, 895 employees (nurses and direct support professional staff) completed this training. This was 100% of all direct support professionals, nurses, and other departmental staff employed at LbSSLC as of September 25, 2012. This was tracked through a "Course Participation Report" of "Observing and Reporting Clinical Indicators of Health Status," a 22-page log of staff and training dates. Training of adverse drug reactions occurred with the PCPs (5/5=100%), with the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		pharmacy staff (5/5=100%), and with the on-duty nursing staff 95/95 = (100%). Two nurses were on leave and had not returned for in-service education. Training of the Medical and Psychiatry Departments (seven staff) occurred from 8/26/11 to 9/21/2011. Training of the pharmacy staff occurred on 8/25/11. Nursing staff training for 95 of 95 nurses was completed during the time period ranging from 9/20/11 to 9/25/12. If not already determined, consideration should be given to providing an annual refresher in-service on core aspects of ADR identification and reporting to ensure all staff remain current in this area. The number of ADRs reported in the prior six months was one. The number of ADR reports that were completed and awaiting P&T Committee review were zero. The number of ADR reports that were discussed at the P&T Committee was one. The conclusion of the P&T Committee on the ADRs reviewed were the following: ▪ None of one ADR reports were concluded to be actual ADRs. ▪ None were reported to the FDA. One did not require further reporting to state/federal government agencies. From the 6/27/12 P&T meeting minutes, an individual developed low white blood cell count and thrombocytopenia, and had been prescribed Valproic acid (VPA) for approximately 10 years. The VPA was held, but three days later, there were low oxygen saturations recorded, and as a precaution, the individual was sent to the ER and subsequently admitted. There were no significant hospital findings, and the lab tests began to normalize. The individual was restarted on half the prior dosage, and there were no further problems. The P&T Committee determined this was a side effect of VPA and not an adverse drug reaction. At the October 2, 2012 P&T Committee meeting, there were no reported adverse drug events reported in the prior quarter. Based on the fact that the Facility had trained all relevant staff on signs and symptoms that required reporting, had a plan to train all new hires, had a system in place that it used for reporting and review of potential ADRs, and had a process to address ADRs should they be confirmed, the Facility was found in substantial compliance with this provision.	
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	A "Drug Utilization Evaluation Calendar" was submitted for the fiscal year 2012-2013 that documented the medications to be included in drug utilization reviews. These included: September 2012 – Intuniv, December 2012 – Levofloxacin, March 2012 – Reclast, and June 2013 – Olanzapine. During the prior six months, two DUE studies were completed:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	▪ At the 6/27/12 P&T Committee meeting, a DUE for Memantine and Donepezil was presented. A total of 10 residents were included in the study, seven of 10 were prescribed both medications. The neurologist saw all. The review for Memantine included indications for use, contraindications for use, precautions and warnings that were to be monitored, and clinical monitoring. Compliance was 100%. Laxative use was also reviewed in those taking Memantine. No significant issues were found. For Donepezil, indications for use, contraindications for use, precautions and warnings to be observed, and clinical monitoring were reviewed. Compliance was 100%. Comorbid cardiology and neurology conditions were reviewed in five individuals. In addition, there were no significant findings to suggest worsening constipation. ▪ A second DUE was completed and presented at the P&T Committee meeting on October 2, 2012. Guanfacine (Intuniv and Tenex) was the medication studied. There were eight individuals prescribed this medication. All individuals were found to have an on label indication or an off label indication that was supported in the literature. There were no contraindications found, and no drug-drug interactions. There were no physiologic contraindications found, such as renal impairment, cardiac arrhythmia, history of acute myocardial infarction, orthostatic hypotension or syncope, and no history of dermatitis, skin peeling, rash or pruritus. All eight individuals were found to have routine blood pressure measurements recorded, and none were taking Phenobarbital or Dilantin. Concomitant use of a benzodiazepine was recorded in two individuals, but there was no evidence of sedation. There was no severe constipation noted. Four were on no laxative and four were on one laxative. Compliance in all areas was 100%. Conclusions and recommendations of the DUES resulted in additional discussion/in-service education of pharmacy/PCPs in none of two of the DUEs. In choosing medications for a drug utilization evaluation, it is important to consider medications being prescribed for which there may need to be increased monitoring or the results of which would have potential to impact the practice patterns of the PCPs. These two studies indicated good compliance and no need for further follow up studies. It is recommended that DUEs be completed for medications that may indicate a change/improvement in practice patterns. To benefit clinical care, it would be advantageous to choose medications that are commonly prescribed that might benefit from improved prescribing practices. The Facility remained in compliance with this provision.	
N8	Commencing within six months of	<u>Policies and Procedures regarding Medication Variances</u>	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	Since the Monitoring Team's last visit, there were no new policies or procedures addressing medication administration that were approved or implemented. There were also no changes in the policies or procedures regarding medication error/variances. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Safety and Systems Committee meetings, which the Clinical Pharmacist chaired. The following describes some of the findings of this committee: ▪ Medication Safety and Systems Committee meetings were held monthly. On 3/19/12, a meeting was held. A pilot project had been introduced in all but two homes in which the medications in the individuals' medication trays were divided per shift. The observation was that this had a positive impact in reducing the number of returned medications. During this committee meeting, the first six months of the fiscal year September 2011 through February 2012 were reviewed for trends. Nursing had an improved process in place to identify and correct Medication Administration Review (MAR) blanks. This led to a marked improvement in this aspect of medication administration documentation. In September 2012, there were 357 MAR blanks, and in February 2012, this had been reduced to 33. ▪ To assist in ensuring medications were administered on the correct shift, and none were overlooked, the RN case managers reviewed the new MARs and highlighted with color-coded lines the break between day and evening shifts. ▪ The May 16, 2012 Medication Safety and Systems Committee minutes documented that all homes had medications divided by day and evening shift as an expansion of the successful pilot project. This allowed for improved efficiency and reduction in potential errors in preparing for the medication administration per shift. There was the concern of inconsistency in MAR printouts for medications requiring more than one tablet per dose, and the pharmacy was to review each profile to ensure consistency for all MARs. ▪ The June 20, 2012 Medication Safety and Systems Committee minutes provided an update from pharmacy in which all data entries for the MARs across campus in which more than one dosage unit was required had standardized language. A baseline for true medication omissions was established for all three Units. ▪ At the July 18, 2012 Medication Safety and Systems Committee, a pilot program at one of the residences was updated. To reduce the medication errors in which medication was given to the wrong individual, on 7/9/12, a protocol was implemented in which identification of the individuals using picture ID cards became a safety mechanism used during the medication administration process. This required cooperation between residential staff and nursing staff and was	

#	Provision	Assessment of Status	Compliance
		determined to be helpful. It was to be expanded to two other homes. Eleven process steps were identified which were implemented. ▪ On August 23, 2012, a Medication Safety and Systems Committee meeting was held. There were several additional steps to reduce omissions and reduce returned medications, including checking the MAR at each shift change by both nurses and signing off, and a more timely review of the "long forms" generated by the medications remaining in the individual's medication tray at the end of the seven day fill period. This process was expected to allow easier/improved investigation by the Nurse Unit Managers in determining additional information for the omitted and returned medications. ▪ On 10/2/12, a Medication Safety and Systems Committee meeting was held. As of 8/7/12, at each shift change, both nurses jointly reviewed the MAR book for that assigned home to ensure all blanks in the MAR were accounted for. This was added to the policy: LBSSLC Protocol for Weekly MAR Checks, dated 9/27/12. Unit Directors continued to make observations of medication passes in each home. These occurred twice per month for March. During each observation, five questions were reviewed. Sparrow and Quail had a different set of questions compared to the other homes on campus, due to the increased number of individuals with complex medical needs residing in these homes. Compliance ranged from 50% to 100% on Sparrow and Quail, and 84% to 100% on the other campus homes. A report of the Medication Pass Activity by Direct Support Professionals in April 2012 documented concerns such as hand-washing, privacy, and identification of the individual. These had corrective action plans. For May 2012, staff encouraged individuals to wash their hands prior to the medication pass in 18 out of 26 observations. Nurses verbally identified the individual in 23 out of 26 observations. One individual at a time was presented to the medication room in 25 out of 26 observations. Of four observations in one residence, three were not considered to occur with privacy. For July 2012, there were no negative trends identified. Hand-washing compliance was observed to be 88%. A medication variance report was reviewed for each Unit during the Medication Safety and Systems Committee meetings. For February 2012, Unit I had 26 medication variances for 11 individuals. There were 24 category A and two category C errors. For Unit II, there were 16 medication variances for seven individuals. One was category A and 15 were category C. For Unit III, there were 10 medication variances for nine individuals. Eight were category A and two were category C. For March 2012, there were three medication variances involving two individuals in Unit I. There were 13 medication variances involving nine individuals in Unit II. There were	

#	Provision	Assessment of Status	Compliance
		five medication variances involving four individuals in Unit III. It was noted that there were no documentation variances for March 2012, indicating improvement that appeared to be due to the improved nursing process/monitoring of MAR blanks. For April 2012, there were nine medication variances involving five individuals in Unit I. One was category D (wrong individual). There were three medication variances involving two individuals in Unit II. There were no medication variances in Unit III. For May 2012, there were five medication variances involving three individuals in Unit I. There were 11 medication variances involving eight individuals in Unit II. There were eight medication variances involving four individuals in Unit III. For June 2012, there were seven medication variances involving seven individuals in Unit I. For Unit II, there were six medication variances involving four individuals. For Unit III, there were four medication variances involving three individuals. For July 2012, there were eight medication variances involving five individuals in Unit I. There were nine medication variances involving six individuals in Unit II. There were four medication variances involving two individuals in Unit III. For August 2012, for Unit I, there were 12 medication errors for eight individuals. There were eight category A and four category C errors. For Unit II, there were 23 medication errors for 15 individuals. There were 12 category A errors and 11 category C errors. For Unit 3, there were 27 medication errors for 16 individuals. There were 20 category A errors and seven category C errors. The pharmacy tracked all errors by type of event originating from the Pharmacy Department, Medical Department, and Nursing Department. Errors were listed in a table format, submitted as "Medication Variances by type of error." For February 2012, there were a total of 52 medication variances. There were 33 charting events, 13 medication omissions, five incorrect doses, and one incorrect time of administration. In March 2012, there were 21 medication variances, of which 20 were dose omissions. For April 2012, there were 12 medication variances, of which 11 were dose omissions and one was an incorrect individual. For May 2012, there were 24 medication variances, of which 20 were omissions of medication. For June 2012, there were 17 medication variances, of which 15 were omissions of medication. For July 2012, there were 21 medication variances, of which 14 were omissions of medication, and six were an incorrect dose. For August 2012, there were no Pharmacy or Medical Department errors. For August 2012, on Unit I, this list documented three medications not given, eight medications	

#	Provision	Assessment of Status	Compliance
		given and not recorded, and one incorrect dose, for a total of 12 errors. For Unit II, there was one error listed as other transcription error, nine medications not given, and 12 medications given but not recorded, and one incorrect dose, for a total of 23 medication errors. For Unit III, there were six medications not given, 20 medications given but not recorded, and one incorrect dose, for a total of 27 errors. Campus-wide, the totals were one transcription error, 18 medications not given, 40 medications given but not recorded, and three incorrect doses, for a total of 62 medication errors for the month. For the September to August 2012 fiscal year, there were 206 medications not given, 29 wrong doses given, five wrong patient medication errors, four wrong time medication errors, six wrong medications given, two other medication errors, and 1149 medications given but not recorded. When removing the last category, that left a total of 252 medication errors, compared to 264 for the prior 2011 fiscal year. For fiscal year 2012 (ending August 2012), there were 1158 category A errors, four category B errors, 233 category C errors, and six category D errors. The committee also tracked unexplained excess medications that were returned to the pharmacy. In February 2012, there were 219 unexplained returned doses of medication from Unit 1. From Unit II, there were 257 unexplained retuned doses. For Unit III, there were 274 unexplained unit doses. In March 2012, there were 85 unexplained returned doses from Unit I. There were 411 unexplained returned doses from Unit II. There were 356 unexplained returned doses from Unit III. In April 2012, there were 150 unexplained returned doses from Unit I. There were 172 unexplained returned doses from Unit II. There were 76 unexplained returned doses from Unit III. In May 2012, there were 239 unexplained returned doses from Unit I. There were 453 unexplained returned doses from Unit II. There were 258 unexplained returned doses from Unit III. For two homes in Unit III, an increased overall trend in returned doses was noted. Nursing attributed these increases to shortages of nursing staff, the increase in resident passes and group home visits, and the inaccurate documentation of medications not given to the individuals when off campus. It is recommended that the Facility determine the number of medication passes needed for a group home visit (e.g., one or two medication passes for a day visit, versus several more for an overnight visit), develop a system to verify the number and types of medications dispensed, develop a MAR system	

#	Provision	Assessment of Status	Compliance
		(if not developed) to record when medications are administered when off site, and develop a system to return unused medications to the home for a medication count, signed by both the staff member returning the individual to the residence and the nurse receiving the returned medication. In June 2012, there were 418 unexplained returned doses from Unit I. There were 399 unexplained returned doses from Unit II. There were 160 unexplained returned doses from Unit III. In July 2012, there were 265 unexplained returned doses from Unit I. There were 301 unexplained returned doses from Unit II. There were 168 unexplained returned doses from Unit III. In August 2012, there were 327 medication units returned from Unit 1, 324 medication units returned from Unit II, and 352 medication units returned from Unit III. The yearly report per month was also provided. For August 2012, the total was 1003. During the prior year, the monthly variation was 398 to 1282. There was discussion that there had been a recent switch to unit dose of Miralax, from bulk stock, as well as lack of documentation when individuals refused the Miralax that may have contributed to the majority of the excess returns to the pharmacy. However, the number of medication units being returned to the Pharmacy on a regular basis was still significantly concerning. More work was needed to determine and address the potential causes. <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. The pharmacy reviewed medication variances for July 2012 for scores rated by nursing as B or greater. Medication variances from all three units were included. It included 21 events. Of these, a sample of 11 (52%) was reviewed. Scoring by Nursing and Pharmacy Departments was the same in all cases reviewed. <u>Medication Error Reports</u> Copies of the last 10 medication error forms were submitted for review. These occurred from 6/1/12 through 6/25/12, and were discovered from 6/4/12 through 7/10/12. Several were identified when an "excess medication form" was completed, and an investigation begun. There were no Class A medication errors, no Class B medication errors, 10 Class C medication errors, and no Class D medication errors. The type of	

#	Provision	Assessment of Status	Compliance
		variance was identified as nine omissions and one wrong dose administered. On review of the medication variances, there were eight omissions and two wrong doses administered. It is recommended that there be a QA system to ensure correct categorization and type of variance that occurs for each medication variance. Follow-up of the errors was documented in 10 of 10 errors through a typed entry on the "Staff follow up" form. <u>Medication Observation Monitoring</u> For February 2012, 23 medication administration passes were observed. No trends were identified. Scores ranged from 94 to 100%. During February's medication pass reviews, PNMP positioning began to be included in the observation form. For March 2012, there were 18 observations completed, with scores ranging from 95 to 100%. There were 15 medication administration observations in April 2012, with scores ranging from 90 to 100%. For May 2012, there were 21 medication administration observations, with scores ranging from 74 to 100%. For June 2012, there were 25 medication administration observations, with scores ranging from 91 to 100%. For July 2012, there were 12 medication observations, with scores ranging from 93 to 100%. For August 2012, there were 16 medication administration observations, with scores ranging from 95 to 100%. The number of medication passes per unit was not determined to ensure an appropriate sample size for observations. A draft of a weighted "Medication Administration Observation" tool was distributed, with weighted scores of three to 10 per clinical indicator. Scores of 10 or higher required nursing retraining/review. The Monitoring Team discussed concerns about the weighting process with the State Office Nursing Coordinator, and it is further discussed with regard to Section M. It will be important to sustain the many endeavors currently in place in making medication administration a quality practice. Structures had been put in place to identify omissions due to administrative concerns and true omissions of medication. Pharmacy, medical, and nursing medication variances were tracked. The remaining concern was the large number of unexplained returned medications. That it occurs on all three units indicates a need for further review in creating a system's approach to resolution. The Pharmacy Department is encouraged to continue to critically analyze the factors that might be contributing to the substantial number of unexplained returned medications. Once the Pharmacy Department assists in developing further successful systems to resolve this, a reduction in this area of medication variance would be expected. Additionally, the Pharmacy Department had been instrumental in creating several other systems to reduce medication variances, and it would be helpful to list/provide a	

#	Provision	Assessment of Status	Compliance
		timeline of the various systems that had been implemented, overlaid with a trend line of reductions in medication variances to show the impact of these various systems and monitoring processes. A periodic report (quarterly, semi-annually, etc.) should be developed to document trends, action steps, and impact of these action steps.	

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

1. 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)
2. As appropriate, the chemical restraint documentation should continue to include recommendations for changes in maintenance medication or changes in the BSP or environmental factors, etc. (Section N.3)
3. The Facility should determine the number of medication passes needed for a group home visit (e.g., one or two medication passes for a day visit, versus several more for an overnight visit), develop a system to verify the number and types of medications dispensed, develop a MAR system (if not developed) to record when medications are administered when off site, and develop a system to return unused medications to the home for a medication count, signed by both the staff member returning the individual to the residence and the nurse receiving the returned medication. (Section N.8)
4. A QA system should be implemented to ensure correct categorization and type of variance that occurs for each medication variance. (Section N.8)

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

1. When completing the patient intervention document in WORx, it is recommended that the name of the medication, dosage, and route be included. For communication with the PCP indicating a change of order, the new order should be documented with the medication, dosage, and route. (Section N.1)
2. To benefit clinical care, it would be advantageous to choose medications for DUE studies that are commonly prescribed that might benefit from improved prescribing practices. (Section N.7)

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 Self-Assessment, Action Plans, and Provision Action Information for Section O; o The following documents for 11 individuals in Sample #1 (i.e., Individual #293, Individual #199, Individual #193, Individual #74, Individual #113, Individual #269, Individual #167, Individual #125, Individual #242, Individual #315, and Individual #128) that included individuals identified with PNM concerns; who received enteral nourishment; and/or had experienced a change of status as evidenced by admission to the Facility emergency room (ER), and/or hospital, including: Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, for individuals hospitalized within this sample the Hospital Liaison Nurse reports across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for six individuals in Sample #2 (i.e., Individual #258, Individual #250, Individual #6, Individual #29, Individual #226, and Individual #12) on the Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months; as well as Individual #168 for whom the PNMT had provided consultation to the IDT and Individual #323 who had been discharged from the PNMT in the past six months: PNMT assessment, PNMT action plan and supporting documentation, HOBE assessment, APEN assessment, annual ISP and ISPAs for past year, IRRF prior to referral to PNMT, IRRF completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, PNMP and dining

	plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, Nursing Care Plan/Integrated Care Plan, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT and corresponding caseload; o List of all individuals assessed by the PNMT and the date of assessment; o List of all individuals discharged by the PNMT; o Physical Nutritional Management Policy and Procedure; o List of continuing education sessions participated in by PNMT members; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff; o Minutes and documentation of attendance for PNMT meetings; o List of changes in PNMT evaluation form; o Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels; o List of individuals with PNM needs; o List of individuals without PNM need; o Wheelchair/Mobility/Assistive Equipment Work Orders; o Completed PNMPs and Dining Plans; o List of tools PNMP Coordinators use to monitor staff compliance; o List of individuals for whom PNM monitoring tools were completed during last quarter; o Tools utilized for validation of staff responsible for PNM monitoring; o Inter-Rater Reliability Scores; o Dining Plan (template) with changes; o PNM and PNMT-related database reports, and spreadsheets generated by Facility; o List of individuals on modified/thickened liquids; o List of individuals who require mealtime assistance; o List of individuals who receive nutrition through non-oral methods; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency; o List of individuals with Body Mass Index (BMI) equal to or greater than 30; o List of individuals with BMI equal to or less than 20; o List of individuals who have had an unplanned weight loss of 10% or greater over a six months period; o List of individuals who have had a choking incident during the past six months; o List of individuals who have had an aspiration and/or pneumonia incident during past six months; o List of individuals who have had a fall during the past six months;

	o List of individuals who have had a decubitus/pressure ulcer during the past six months; o List of individuals who have experienced a fracture during the past six months; o List of individuals who have had a fecal impaction during the past six months; o List of individuals who are non-ambulatory or require assisted ambulation; o List of individuals with poor oral hygiene; o List of individuals who received a feeding tube since the last review; o List of individuals who are at risk of receiving a feeding tube; o List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; o Schedule of meals by home; o Schedule of all PNM-related meetings occurring during the week of the onsite review; o Curricula on PNM used to train new staff responsible for directly assisting individuals; o Agenda and curriculum for competency-based annual refresher training related to PNM; o List of completed PNMT Nursing Post Hospitalization Assessment/Evaluations; o The following documents for Individual #250 and Individual #2 on the PNMT caseload were submitted prior to the onsite review: PNMT Minutes, PNMT Assessments, Integrated Risk Rating forms, APEN Assessments, HOBE Assessments, PNMT Action Plans, Staff Competency-based Check-offs, PNMT Monitoring Forms, individual PNMPs, PNMT Nursing Post Hospitalization Assessments, and ISPA meeting documentation related to integration of PNMT assessments and Action Plans; o Quality Assurance/Quality Improvement meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; o Minutes from the HT Department meetings for the past six months; o External PNM consultant reports since last review; o Changes to Physical Nutritional Management Plan templates since last review; o Raw data for Section O monitoring; o QA/QI Quarterly Section Review for Section O for last two quarters; o List of individuals who require positioning assistance associated with swallowing activities; o List of individuals who have difficulty swallowing; o Facility policy or criteria for individuals who require a PNMP; o Facility policy for implementation of PNMPs off-campus; o Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n) over number of staff in new employee orientation over last six months (N); o Number of current staff who have successfully completed PNM performance check-offs (n) over number of current staff (N); o Number of current staff who have completed annual refresher training (n) over number of staff required to complete annual refresher training (N); o Pneumonia Avatar tracking; o Samples of physical nutritional management competency performance check-offs for new employee orientation;

	○ Samples of PNM competency performance check-offs for current staff; ○ Policy for pulled/relief staff; and ○ Performance check-offs completed for most recent PNMP Coordinator hired. ▪ **Interviews with:** ○ Linda Thomas, OTR, Director of Habilitation Therapy and Acting PNMT Coordinator; ○ Latrell Castanon, Dedicated PNMT RN; ○ Corey Verett, Chief Dietician and PNMT Dietician; ○ Jon Olive, PNMT PT; ○ Melissa Olive, PNMT Physical Therapy Assistant (PTA); ○ Stephanie Carillo, MS, CCC/SLP; ○ Denise Juarez, MOTR; and ○ Members of Mealtime Improvement Committee (i.e., Assistant Director of Programs, Unit Director, and Safety Representative). ▪ **Observations of:** ○ Individuals in 504W, 504E, 528 N Cedar, and 521 N Cedar; ○ Morning Provider meeting, on 10/3/12 and 10/4/12; ○ QA/QI Meeting, on 10/3/12; and ○ PNMT Follow-Up meeting, on 10/4/12.
	Facility Self-Assessment: The Director of HT submitted a Self-Assessment for Section O, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section O, in conducting its self-assessment, the Facility: ▪ The Facility used monitoring/auditing tools. At the time of the review, the Director of HT was in the process of modifying the monitoring tool for Section O. The Director of HT had worked collaboratively with a Habilitation Therapy State Consultant and the Director of HT at AUSSLC to develop a template for Self-Assessment data. The template included the addition of tables to present compliance data within subsections. For example, in Section O.1, charts had been developed to report on core PNMT attendance summary, IDT/PNMT Attendance Summary, and PNMT continuing education hours. Each of the eight sections for Section O included indicators to track compliance that were relevant to making compliance determinations. The development and future implementation of the template was a positive step forward in presenting relevant data to substantiate compliance. Based on a review of the Facility Self-Assessment: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Compliance Monitoring Tool. The QA/QI Council had approved the suspension of the Settlement Agreement Monitoring Tool due to limited therapist resources. In addition, the Director of HT acknowledged that the current Monitoring Tool was not sufficient to assess compliance with the provisions of the Settlement Agreement. As noted above, the Director of HT was in the process of revising the Monitoring Tool for Section O. ○ This monitoring/audit tool (i.e., Compliance Monitoring Tool) did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement.

	The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. The development of the template for the presentation of data was a very promising step forward in aligning the items to be monitored with the elements of the Settlement provisions and the Monitoring Team's indicators. o The monitoring tool did include adequate methodologies, such as observations, record review and staff interview. . o The Self-Assessment identified the sample(s) sizes. However, the Facility template guidelines should identify how sample sizes were to be chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Facility therapists (i.e., OTs, PTs, and SLPs) and a Program Compliance Monitor. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed lists of individuals with PNMPs, had compared these to other lists, and conducted reviews to identify additional individuals that required PNMPs. However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. For example, the Facility should develop include data about competency-based training and performance check-offs for new employees and current staff. It also should develop key indicators or outcome measures in relation to the provision of physical and nutritional management supports. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: The Facility provided a list of core Physical and Nutritional Management Team members, including an Acting Coordinator, dedicated Nurse, PT, Physical Therapy Assistant (PTA), OT, SLP, and RD. Since the last review, the Facility Hospital Liaison Nurse was identified as the backup for the PNMT RN. Prior to the onsite review, the previous PNMT Coordinator/SLP and PNNT

	OT had resigned from their positions. As a result of these resignations, the Director of HT assumed the role as the PNMT Acting Coordinator. The Director of HT indicated that an OT on staff was in the training phase for the PNMT OT position, and one of the current SLPs would assume the role of the PNMT SLP. The Facility PNMT Guidelines had been revised in August 2012, and these revisions were positive additions to provide further guidance to the PNMT and IDT members. However, the IDTs had not been provided training on the guidelines. The PNMT Nurse attended the daily morning provider meetings. This provided opportunity to update clinical staff on the status of individuals on the PNMT caseload, as well as present systemic issues for discussion and resolution. The PNMT had developed and implemented audit tools for the PNMT assessment and Follow-Up. These tools were implemented in August 2012. A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans, because multiple components were missing. On a positive note, through its self-auditing process, the Facility had begun to identify some of these issues itself. Lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate (i.e., individuals who require mealtime assistance, individuals at high and medium risk for PNM concerns, individuals who had difficulty swallowing). The Director of HT acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists. Since the last review, the therapists had revised PNMPs to include individual-specific risks and triggers. This resulted in positive additions to the PNMPs. However, a review of the list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP. The Monitoring Team and members of the PNMT team completed direct observations of the implementation of PNMP strategies in residences for individuals on the PNMT caseload. These observations revealed that some staff were, but others were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems. The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual's progress or to assess if the individual was better or worse, monthly progress notes were not completed to report on the effectiveness of an individual's supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis.

	The Facility was in the process of implementing a new APEN process in conjunction with the new ISP process. However, the Facility was in the beginning stages of implementing it, and, at the time of the review, ISPs did not yet provide justification for the continued use of the tube as medically necessary, or identify the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

#	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, 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	As noted above with regard to the documents reviewed section, two samples were selected for the review of Section O. These included: ▪ **Sample #1 (IDT Caseload) -** 11 individuals identified with PNM concerns who received enteral nourishment, and some of whom had experienced a change of status related to PNM difficulties as evidenced by an admission to the Facility Infirmary, emergency room and/or hospital, including: Individual #293, Individual #199, Individual #193, Individual #74, Individual #113, Individual #269, Individual #167, Individual #125, Individual #242, Individual #315, and Individual #128. ▪ **Sample #2 (PNMT Caseload) -** six individuals on the current PNMT caseload who were assessed or reviewed in the last six months, including: Individual #258, Individual #250 Individual #6, Individual #29, Individual #226, and Individual #12. This sample also included Individual #168 for whom the PNMT had provided consultation to the IDT, and Individual #323 who had been discharged from the PNMT in the past six months. 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. 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. In addition, Section O.1 specifically requires that: "the 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 PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team." The status of these requirements is discussed with regard to Section O.3.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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><u>PNMT Membership</u>
The Facility provided a list of core Physical and Nutritional Management Team members, including an Acting Coordinator, dedicated Nurse, PT, Physical Therapy Assistant (PTA), OT, SLP, and RD. Since the Monitoring Team's last review, the Facility Hospital Liaison Nurse was identified as the backup for the PNMT RN. However, the Facility PNMT Guidelines did not discuss the role and responsibilities of the backup PNMT Nurse. Prior to the onsite review, the previous PNMT Coordinator/SLP and current PNNT OT had resigned from their positions. As a result of these resignations, the Director of HT assumed the role as the PNMT Acting Coordinator. The Director of HT indicated that an OT on staff was in the training phase for the PNMT OT position, and one of the current SLPs would assume the role of the PNMT SLP.

The following chart provides the caseloads of core PNMT members at the time of the review:

<table>
<tr><th>Core PNMT Members</th><th>Current Caseloads</th></tr>
<tr><td>Director of Habilitation Therapy</td><td>The Director of HT was the Acting PNMT Coordinator</td></tr>
<tr><td>Registered Nurse</td><td>Dedicated member, supported 18 individuals on the PNMT caseload</td></tr>
<tr><td>Occupational Therapist</td><td>Supported 18 individuals on the PNMT caseload, and in addition, 94 individuals on 513, 516, 518, 523, 525, 526, and 527</td></tr>
<tr><td>Speech Language Pathologist</td><td>Supported 18 individuals on the PNMT caseload, and in addition, 68 individuals on 504W, 513, 514, 523, and 526</td></tr>
<tr><td>Registered Dietician</td><td>Chief Dietician and supported 18 individuals on the PNMT caseload</td></tr>
<tr><td>Physical Therapist</td><td>Supported 18 individuals on the PNMT caseload, and in addition, 96 individuals on homes 516, 515, 525, 520, and 514</td></tr>
<tr><td>Physical Therapy Assistant</td><td>Not assigned a caseload</td></tr>
</table>

As noted in the chart above, the PT, OT, and SLP had caseloads beyond their responsibilities for individuals on the active PNMT caseload. At the time of the Monitoring Team's review, no analysis of caseloads or staffing needs had been completed. The HT Director should initiate an analysis of the current clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators), as</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		well as the various duties of clinicians to determine if the current staffing as well as the caseload distribution are adequate and appropriate. **Ancillary PNMT Members** With regard to PNM ancillary members, the Facility's PNMT Guidelines stated: "upon request the team shall include designated PNMT physician, nursing case managers, assigned therapists, psychologists, QDDPs, home supervisors, facility support services staff and others." **Continuing Education** In the Facility's PNMT Guidelines, the definition for the PNMT stated: "all core team members should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs." However, the Guidelines did not specifically address continuing education requirements for PNMT members. Attendance rosters, course certificates of completion, and agendas were submitted. Based on review of this documentation, seven of the seven core PNMT members (i.e., Director of HT and Acting PNMT Coordinator, former PNMT Coordinator/SLP, PT, former OT, RN, RD, and PTA) (100%) attended community continuing education courses. Core PNMT members attended the following continuing education courses that provided specialized training in working with individuals with complex physical and nutritional management needs: ▪ On 5/1/12, a presentation by Abbott Nutrition Infinity Pump; ▪ On 5/31/12, the Infection Control course: Germblast Presentation; ▪ On 6/6/12, Addressing Feeding Issues for Students with Autism Spectrum Disorder; ▪ On 6/7/12, the Sensory-Based Strategies for Community, Home and School; ▪ On 6/7/12, Transition Planning is a Strength Based Process; ▪ On 6/20/12, Grinbath Eye Guide Assist; ▪ On 7/19/12, PKU in the Cognitively Impaired Adult; ▪ On 7/24-25/12, Risk Training; ▪ On 7/25/12, Dysphagia: A Growing Concern in Healthcare; ▪ On 7/27/12, Drugs and Dysphagia: How Medications Affect Eating and Swallowing; ▪ On 8/1/12, Anatomy of Swallowing; ▪ On 8/1/12 to 8/2/12, Evidence-Based Practices for AAC Evaluation – From A & P to REC: Building the Meaning Behind the Acronyms; and ▪ On 8/29/12, the Advance Enteral Solutions. The former PNMT OT was a presenter for the course entitled Positioning and	

#	Provision	Assessment of Status	Compliance
		Presentation for Medication Administration at Corpus Christi SSLC in May 2012. In addition, the former PNMT OT presented the Role of the Occupational Therapy at LBSSLC on 4/16/12. In summary, these continuing education training sessions PNMT members completed were relevant to providing supports to individuals at highest risk for physical and nutritional issues. **PNMT Meetings** The Facility PNMT Guidelines indicated PNMT review meetings would be held at least weekly and as scheduled, but would also occur: ▪ When an individual's risk levels changed; ▪ When nutritional/health problems arose; ▪ After a Modified Barium Swallow study or other medical diagnostic tests were performed; ▪ Before final treatment decisions were made; ▪ To perform follow-up activities; and ▪ At any phase in the physical nutritional management process. On a positive note, the PNMT met more than once a week to complete follow-up on individuals on their caseload. Designated PNMT member attendance for 72 meetings conducted during the time frame from 4/4/12 to 7/26/12 was: ▪ PNMT SLP: 54%, and with back-up SLP attendance added, a total of 92%; ▪ PNMT RN: 74%; ▪ PNMT OT: 51%, and with back-up OT attendance added, a total of 89%; ▪ PNMT PT: 40%, and with back-up PT attendance added, a total of 92%; ▪ PNMT PTA (not required): 71%; and ▪ PNMT RD: 76%, and with back-up RD attendance added, a total of 92%. The Facility PNMT Guidelines should address attendance by PNMT members, and/or how the PNMT would address the absence of core PNMT members. Attendance by ancillary PNMT members for PNMT meetings conducted during the time frame from 4/4/12 to 7/26/12 was as follows: ▪ The Facility PNMT medical liaison and/or PCP attended 21 PNMT meetings (29%); ▪ QDDPs attended 67 meetings (93%); ▪ RN Case Managers were present in 64 meetings (89%); ▪ Residential Coordinators attended 44 meetings (61%); and ▪ A Respiratory Therapist was present for one meeting (less than 1%).	

#	Provision	Assessment of Status	Compliance
		PNMT Facility Policy The Facility PNMT Guidelines, effective August 2012, had been updated since the Monitoring Team's last review. The PNMT Guidelines had been amended to define: the responsibility of the PNMT, the referral process to the PNMT, the process for developing and implementing PNMT recommendations with Integrated Health Care Plans, the criteria for PNMT discharge, and the PNMT consultation process with the IDT. In addition, definitions were provided for the PNMT, PNMT Evaluation, PNMT Follow-Up, PNMT Consult, Aspiration Pneumonia/Enteral Nutrition Data Sheet, Competency-Based Training, Dining Plan, IDT, Integrated Progress Notes, Individual Support Plan, Physical Nutritional Management Plan, Change of Status, and Risk Level. The responsibilities of the PNMT RN had been included. The additions to the PNMT Guidelines were positive. However, the Guidelines should incorporate the thresholds discussed in the PNMT Episode Tracker document to provide additional direction to the IDTs, define the responsibility of attendance by core PNMT members at PNMT meetings, and discuss how systemic issues will be documented and resolved. The PNMT RN's responsibilities included attending the daily morning provider meetings. In addition, on Friday mornings, the PNMT RN presented an update on the status of individuals on the PNMT active caseload. Based on interview with the Director of HT, a PNMT Episode Tracker System was in the process of development. The PNMT RN was to be responsible for tracking the following episodes for all individuals: ▪ Decubitus (i.e., including Stage) including delayed healing; ▪ Fractures of long bones, pelvis, or spine; ▪ Choking episodes; ▪ Emesis; ▪ Pneumonia (i.e., bacteria, aspiration, and/or unknown); ▪ Weight loss (i.e., 5% in one month, 7.5% in three months, and/or 10% in six months); ▪ Body Mass Index 30 or greater; ▪ Body Mass Index 20 or less; ▪ Hospitalization for respiratory compromise, urinary tract infection, gastrointestinal issues, bowel obstruction, fecal impaction, and dehydration; ▪ At risk for receiving enteral nutrition; ▪ Abnormal Modified Barium Swallow Study; ▪ Poor oral hygiene; ▪ Urinary tract infection; ▪ New enteral nutrition; and ▪ Any other episode that might impact an individual's physical and nutritional	

#	Provision	Assessment of Status	Compliance
		status. The PNMT RN would document episodes for all individuals with the purpose of achieving a full year of data to analyze trends in pneumonia and hospitalizations. In addition, episode thresholds for an objective referral to the PNMT would include the following at a minimum: ▪ Two aspiration pneumonias in one year; ▪ Two choking episodes in one year requiring abdominal thrust; ▪ Unresolved vomiting (greater than three episodes in 30 days not related to a viral infection; ▪ Any Stage three or four decubitus with delayed healing; ▪ Significant unplanned weight loss; ▪ New or proposed enteral nutrition; ▪ Two hospitalizations related to bowel obstruction/dysmotility; ▪ Fracture of long bone, spine or hip; and ▪ Results of PNMT RN post-hospitalization assessment. The development of these criteria was positive. However the PNMT members should reexamine some of these thresholds. For example, the PNMT should be involved before an individual experiences two aspiration pneumonia events in one year. In addition, significant weight loss should be defined to assist IDTs in making a timely referral. In addition, these criteria should be integrated in the Facility PNMT Guidelines to further define referral to the PNMT. Consultation by the PNMT would include but not be limited to: ▪ Any choking incident; ▪ Unresolved aspiration triggers as referred by the RN Case Manager; ▪ Abnormal findings in a Modified Barium Swallow study, upper gastrointestinal test (UGI), and/or an esophagogastroduodenoscopy (EGD); ▪ Unresolved vomiting; and/or ▪ Hospitalization related to respiratory compromise and/or gastrointestinal bleed. Again, these criteria should be integrated in the Facility PNMT Guidelines. The Integrated Clinical Services Committee's goal was to "not experience a significant increase in the number of tertiary care and clinic visits by recognizing indicators/triggers, completing appropriate assessments and timely notification of status changes." The expected positive outcomes were: ▪ Individuals will have fewer hospitalizations; ▪ Individuals will have fewer clinic visits; ▪ Individuals will have fewer ER visits; ▪ Individuals will receive timely and appropriate preventative care; ▪ Reduction in incidents of aspiration pneumonia; and	

#	Provision	Assessment of Status	Compliance
		▪ Improved quality of life and health for individuals the Facility supported. The goal and defined outcomes of this committee was a positive development. However, there was no PNMT representation on this committee. The Facility should consider having PNMT representation given that the committee's goal and outcomes were in alignment with the purpose of the PNMT. **PNMT Systemic Issues** Progress had been made in tracking the resolution of PNMT systemic issues. A tracking system to address resolution of PNMT systemic concerns was implemented in April 2012. The system tracked the concern, responsible PNMT member, other responsible person(s), outcome, evidence, date, status and other/comments. The following concerns were identified: ▪ Need for system for warming blankets/clothing; ▪ System-wide consistent means for identifying and documented loose stools versus diarrhea; ▪ Isolation and infection control with one person and/or for more than one person in a room; ▪ Air filtering systems; ▪ IPN documentation requirements; ▪ APEN disciplines not having access to document; ▪ Physician understanding role of PNMT and PNMT RN; and ▪ Size of pressure cuffs being used. A review of the systemic concerns chart indicated that some of the issues had been resolved. However, a final resolution was not reported for other issues. On 6/14/12, for example, the PNMT OT raised the issue of air filtering systems. The chart stated: "PNMT asked Director of Support Services to review for any other filtering of if is needed (sic). More information was provided/will schedule a meeting with all involved departments [during] week of 10/8/12." The resolution of this issue should not have taken over four months. If a systemic issue was not being resolved in a timely fashion, the PNMT had the responsibility to inform supervisors and/or Administration to achieve a timely resolution. In addition, the PNMT Nurse attended the daily morning provider meeting. This provided an opportunity to present and resolve identified systemic concerns.	
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	**Facility's Lists of Individuals with PNM Problems** The Facility produced the following lists identifying individuals with PNM concerns: ▪ The Facility's list of individuals requiring mealtime assistance, updated 8/20/12, reported 151 of 211 individuals (72% of the census) were found to require mealtime assistance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ Fifty-four individuals (26% of the census) were identified at high risk, and 84 individuals (40% of census) were identified at medium risk for aspiration according to the LBSSLC Integrated Health Status List, dated 9/4/12. The State recently had revised the criteria for high risk of aspiration to include all individuals who received enteral nutrition. As a result of this change, IDTs will need to revise the risk rating for aspiration for individuals who receive enteral nutrition. Ten of the 46 individuals (22%) (i.e., Individual #37, Individual #16, Individual #17, Individual #321, Individual #269, Individual #191, Individual #97, Individual #223, Individual #21, and Individual #2) who received enteral nutrition were ranked at medium risk for aspiration. ▪ Fifty-nine individuals (28% of the census) were identified as being at high risk, and 106 (50% of the census) at medium risk for choking. The Facility reported one serious choking incident for Individual #156 that occurred on 8/2/12. This individual was rated at high risk for choking, which was appropriate. However, the LBSSLC Health Status List did not provide updated risk levels for other individuals. Current risk ratings for some individuals in Sample #1 were not captured in the LBSSLC Health Status List (i.e., Individual #167, Individual #242, Individual #125, and Individual #273). Furthermore, for one individual, the Health Status List noted the date of the meeting, but the IRRF submitted was not reflective of this date (i.e., Individual #128). Consequently, the LBSSLC Health Status List was not accurate. ▪ The Facility's list of individuals who had difficulty swallowing, not dated, (i.e., TX-LB-1210-NW.5 provided to the Monitoring Team while on site) identified 81 individuals. However, the following individuals who received a Modified Barium Swallow study and received a diagnosis of dysphagia were not identified on this list: Individual #259, Individual #1, Individual #74, and Individual #250. Consequently, this list was not accurate. In its comments to the draft report, the State/Facility indicated a document provided in response to the pre-review document request included correct information. It is unclear why a presumably more up-to-date list (i.e., provided as part of the Monitoring Team's onsite requests) would include less accurate information. ▪ The Facility list of individuals who required positioning assistance associated with swallowing, not dated, identified 97 individuals (46% of the current census). The LBSSLC Health Status List was missing the risk ratings for infections. Individuals' risk rating for infections should be included on the list. At the time of the review, the HT Director acknowledged there were no Facility policies and/or procedure(s) to define the criteria for the development of these lists and/or a formal process for maintaining, updating, and sustaining the accuracy of these lists. In	

#	Provision	Assessment of Status	Compliance
		addition, the Section I Lead indicated the list of individuals' risk ratings was not accurate, because the Facility had not developed a maintainable system to report risk ratings in a timely manner. Consequently, as noted above, the multiple lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate. The Facility should develop a sustainable system to maintain and update these lists to ensure their validity. A basic component of compliance with this provision is the accurate identification of individuals with PNM concerns. Without an accurate list(s), it would be difficult for the Facility to ensure that it provides such individuals with adequate physical and nutritional interventions. **PNMT Referral Process and Initiation of Assessment** The Facility PNMT Guidelines indicated: "the IDT, PCP and/or the PNMT may refer individuals identified as being at a specific high risk for whom the IDT requires assistance/specialized services," and "an order for the referral from the IDT/Physician will be sent to the PNMT requesting an assessment." Based on interview with the Director of HT, the Facility IDTs had not been provided training on the Facility PNMT Guidelines at the time of the Monitoring Team's onsite review. A review of individuals' records in Sample #1 revealed that the IDTs had not referred individuals to the PNMT who had been hospitalized with PNM concerns (i.e., aspiration pneumonia and vomiting). A subsample of nine individuals in Sample #1 who had been hospitalized [i.e., Individual #293 (dehydration), Individual #199 (ER for G-tube dislodgement), Individual #193 (respiratory distress syndrome), Individual #74 (convulsions), Individual #113 (pneumonia), Individual #269 (respiratory distress syndrome), Individual #167 (respiratory distress syndrome), Individual #242 (abnormal lab findings), and Individual #128 (vomiting)] were reviewed to determine if a referral had been made to the PNMT, if appropriate. Based on the Facility's current criteria, one of these individuals (i.e., Individual #113) should have been referred to the PNMT. On 7/3/12, Individual #113's ISPA, dated 7/5/12, noted: "[Individual #113] underwent a procedure for placement of a PEG [percutaneous endoscopic gastrostomy] tube." The ISPA indicated the IDT/PNMT and [Individual #113's] physician were all in agreement for a PEG placement. However, there was no documentation that Individual #113 had been referred to the PNMT for an assessment and/or consultation. This example highlights the need for the provision of training to the IDTs on the Facility PNMT Guidelines. In addition, as noted above, the Monitoring Team had concerns about the Facility's decision to allow two aspiration pneumonias to occur before referral to the PNMT. With the more appropriate criterion of one incidence of aspiration pneumonia, more individuals in this group would have required referral to the PNMT (e.g., Individual #193, and Individual #269).	

#	Provision	Assessment of Status	Compliance
		PNMT Assessment At the time of the Monitoring Team's onsite review, the active PNMT caseload was 18 individuals. The Facility PNMT Guidelines outlined the purpose of the PNMT; general responsibilities of PNMT members; specific responsibilities of the PNMT RN, RD, PT, SLP, and Clerk; IDT responsibilities; IDT risk process, referral to the PNMT; change of status; PNMT process; PNMT recommendations; plan implementation; documentation; integration of PNMT interventions; PNMT discharge and return to IDT; and PNMT meetings. The PNMT was responsible for "performing a collaborative assessment and determine (sic) the appropriate interventions of specific risk and related areas for referred/self-referred individuals identified as being at a specific high risk and for who the IDT requires assistance and specialized services." The Monitoring Team reviewed the content of PNMT assessments and action plans for six of the 18 individuals in Sample #2, who were on the active PNMT caseload (representing a sample of 33%) and found: ▪ None of the six individual PNMT assessments reviewed (0%) were adequate to identify the physical and nutritional interventions and supports sufficient to meet the individuals' needs. For example: o None of the six individual PNMT assessments reviewed (0%) followed the State and/or Facility-established PNMT assessment template. PNMT assessments reviewed were missing components from the Facility PNMT assessment format. o In none of six individual PNMT assessments reviewed (0%), the assessment identified the cause of the individual's physical and nutritional management problems. PNMT assessments did not provide an adequate analysis to identify the cause of the individual's PNM concerns. o In three of the six individual PNMT assessments reviewed (i.e., Individual #250, Individual #6, and Individual #12) (50%), a PNMT self-referral and/or IDT referral date was noted. o In one of the six individual PNMT assessments reviewed (i.e., Individual #6) (17%), the assessment reviewed and updated the individual's risk rating(s), as appropriate. In assessing this indicator, the Monitoring Team specifically considered the risk ratings related to individuals' PNM needs. o In none of six individual PNMT assessments reviewed (0%) was there documentation of adequate PNMT assessment of an individual's PNM related high and medium risk levels. For individuals whose PNMT assessments had been completed prior to the risk rating process, the PNMT should have updated the PNMT assessment to reflect the results of a completed IRRF, because the individual's risk ratings should drive	

#	Provision	Assessment of Status	Compliance
		the content of the PNMT assessment. Although, the PNMT might have reviewed an individual's risks, an IRRF was not completed to provide justification and rationale for the risk rating changes. o For five of the six individuals reviewed (83%), a HOBE assessment had been completed. However, the HOBE assessment format did not include an assessment of a recommended safe range for dental procedures. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. o In none of the six individual PNMT assessments reviewed (0%) were individual-specific clinical baseline data established to assist teams in recognizing changes in health status. o In none of the six individuals' PNMT assessments reviewed (0%) were individualized clinical criteria defined regarding when nursing staff should contact the PNMT. Given that multiple components as identified above were not present, PNMT assessments were not adequate. **PNMT Action Plan** The Facility PNMT Guidelines stated the PNMT: "will meet with the IDT to discuss and incorporate the recommendations addressing the specific risk with measurable goals and outcomes into the ISP and integrated health care plan." However, a review of individuals' PNMT action plans did not show that the action plans included essential components discussed below. The Monitoring Team reviewed the six individuals' PNMT action plans and found: ▪ In none of the six individuals' PNMT action plans reviewed (0%), the plan adequately addressed the individual's identified PNM problems as presented in the PNMT assessment. The PNMT action plans were missing information and recommendations from the PNMT assessments. In addition, the PNMT action plans did not provide adequate interventions to resolve an individual's PNM problems. ▪ In one of the six individuals' PNMT action plans reviewed (i.e., Individual #258) (17%), the HOBE recommendations were integrated into the PNMT action plan. ▪ In none of the six individuals' PNMT action plans reviewed (0%), adequate preventative interventions were included in the plan to minimize the conditions of identified risk indicators. Although there were some preventative measures, additional preventative measures were needed to address all of the individuals' needs.	

#	Provision	Assessment of Status	Compliance
		▪ In none of the six individuals' PNMT action plans reviewed (0%) were there appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. ▪ In none of the six individuals' PNMT action plans reviewed (0%), the plans included the specific clinical indicators to be monitored. For example, action plans did not consistently identify clinical indicators to be monitored by nursing and/or the PNMT members that would indicate the individual's health status was stable and/or the individual was experiencing a change of status. Although some indicators were included, many were not adequate to appropriately measure individuals' health status, and many were missing. ▪ In six of the six individuals' PNMT action plans reviewed (100%), the frequency of monitoring was included. However, the frequency of monitoring was not adequate. For example, the PNMT nurse was to monitor every two weeks and/or once a month, which not sufficient for individuals at high risk. ▪ In six of the six individuals' PNMT action plans reviewed (100%), the action plan was integrated into the ISP. ▪ For six of the six individuals reviewed (100%), a PNMT/IDT meeting had been conducted to discuss the Integrated Risk Rating Form, PNMT assessment, and action plan. ▪ In none of six individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of PNMT action plan within 14 days of the plan's finalization. Given that multiple components as identified above were not present, individuals' PNMT action plans were not adequate. **PNMT Follow-up and Problem Resolution** A review of PNMT follow-up meetings for individuals on the active caseload of the PNMT in Sample #2 showed: ▪ In none of the six individuals' PNMT action plans reviewed (0%), action plan steps had established timelines. Action plans provided a timeline start date but did not provide a timeframe for completion of action steps. ▪ In none of the six individuals' PNMT action plans reviewed (0%), action plan steps had been completed within established timeframes. It was difficult to discern when action plan steps had been completed. ▪ In none of the six individuals' PNMT action plans reviewed (0%), when risk to the individual warranted it, the PNMT took immediate action. For example, individuals' Aspiration Trigger Data Sheets were not completed and/or individual-specific triggers had not been integrated into the form. These forms were developed and implemented to alert staff to an individual's changes in status and subsequently, alert PNMT members. The PNMT should have been	

#	Provision	Assessment of Status	Compliance
		aggressive in ensuring staff implemented these forms as well as modifying the forms to reflect individuals' triggers. ▪ In none of the six individual records reviewed (0%), documentation was present for adequate closure of PNMT action plan steps. **<u>Individuals Discharged by the PNMT</u>** The Facility PNMT Guidelines noted: "when the individual has met the stated objective as determined by the PNMT/IDT and the specific risk has been stabilized and/or reduced with the interventions in place, the PNMT will meet with the IDT who will be responsible for the continuation of the plan." The PNMT was responsible for providing and documenting the following information in collaboration with the IDT: plan and interventions implemented, evidence and efficacy data, monitoring forms, data from all assessments completed by the PNMT, assessments and consults from other specialists, tracking data, training forms, recommendations and implementation, staff responsibilities, ongoing monitoring and review schedule to ensure continued implementation and efficacy, and criteria for referral back to the PNMT. The PNMT provided a list of individuals, dated 8/20/12, and their current status. Since the last review, the PNMT had discharged two individuals (i.e., Individual #323 and, Individual #235). The Monitoring Team reviewed the records of Individual #323 and findings were as follows: ▪ In one of the one individual record reviewed (100%), an ISPA meeting occurred. ▪ In none of the one individual record reviewed (0%), the ISPA meeting provided objective clinical data to justify the discharge. The PNMT Follow-Up meeting, dated 3/15/12, presented multiple concerns that should have required further support and/or monitoring by the PNMT prior to discharge. The following concerns were noted: o No documented resolution had occurred of the question of whether Individual #323's neck collar could be removed without risk of harm and/or jeopardy to oxygen levels. o Aspiration Trigger Data Sheets had not been completed for the month of March. During conversations with staff, the PNMT SLP discovered that staff were "unaware of what the Aspiration Trigger Sheet was, where it was located, or what to document." The PNMT SLP, QDDP, and RNCM provided training for staff. However, this was a significant concern that required ongoing monitoring. o On 3/15/12, a mealtime observation completed noted significant concerns with coughing and the resulting nursing interventions. o The APEN required further editing/updating. ▪ In none of the one individual record reviewed (0%), there were adequate criteria for referral back to the PNMT. The discharge plan stated: "IDT to refer to	

#	Provision	Assessment of Status	Compliance
		PNMT upon change of status." The PNMT should provide individual-specific, objective, clinical data that would indicate a change of status. These referral criteria did not support a proactive approach. The ISPA indicated: "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 feels there is a concern that needs PNMT attention." The discharge of this individual from the PNMT did not follow the established Facility PNMT Guidelines. On a positive note, audits of PNMT assessments and follow-ups had been initiated. The PNMT audit tool should be expanded to include the essential components included within this section.	
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>Identification of Individuals Requiring a PNMP</u>** The Facility provided a list, not dated, that identified 17 of 211 (8%) individuals who had PNM needs. An additional list noted 186 of 211 (88%) individuals did not have PNM needs. However, PNMPs, which included dining plans, were presented for 173 individuals (82% of the census), indicating these individuals had PNM needs. Thirty-nine individuals had a dining plan, but did not have a PNMP. However, a review of some the 39 individuals with dining plans indicated that some of these individuals had PNM needs as evidenced by a high and/or medium risk ranking in choking, aspiration, weight, skin integrity, and/or falls. However, these individuals did not have a PNMP. The State PNM policy stated: "all individuals who require physical nutritional management services will be furnished with a PNMP or mealtime and positioning/dining plan. All individuals who cannot feed themselves are at risk for choking or aspiration, and who require positioning associated with swallowing will be identified and provided with plans and supports sufficient to meet their needs." The following concerns were noted for individuals who received a high and/or medium PNM-related risk ranking, but did not have a PNMP: ▪ An individual's high and/or medium risk rating for aspiration indicates the need for a PNMP. Individual #164 did not have a PNMP, but were ranked at medium risk for aspiration. ▪ Individuals at risk for choking have a need for a PNMP. Individual #164 was ranked at medium risk for choking but did not have a dining plan. ▪ Individuals at high and/or medium risk for falls had a need for a PNMP. Individual #164 did not have a PNMP and/or dining plan. The following individuals did not have a PNMP, but were ranked at high and/or medium risk for falls: Individual #164, Individual #22, Individual #284, Individual #279, Individual #266, Individual #230, and Individual #33. ▪ Individuals at high and/or medium risk for skin integrity required a PNMP. However, individuals were identified without a PNMP, but were ranked at medium risk for skin integrity, including: Individual #38, Individual #220,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #230, Individual #255, and Individual #272. ▪ Individuals at high and/or medium risk for weight indicated the need for a PNMP. However, the following individuals were ranked at high risk for weight did not have a PNMP: Individual #36, Individual #57, Individual #7, Individual #99, Individual #61, Individual #284, Individual #220, Individual #60, Individual #112, Individual #19, Individual #310, Individual #98, Individual #255, Individual #272, and Individual #33. Based on the examples above, some individuals that had been identified as not having PNM needs might have required a PNMP. The HT Department should follow the State Office policy for individuals who require a PNMP. The State Office policy should be utilized to review the Facility's list of individuals with no PNM needs to determine which of these individuals meet the PNM criteria and should be provided with a PNMP sufficient to meet their needs. **PNMP Format and Content** A review of 11 individuals' PNMPs who received enteral nutrition, were ranked high for PNM concerns and/or had experienced a change in status related to PNM concerns (i.e., Individual #293, Individual #199, Individual #193, Individual #74, Individual #113, Individual #269, Individual #167, Individual #125, Individual #242, Individual #315, and Individual #128) in Sample #1 found: ▪ Eleven of the 11 individuals (100%) had a PNMP. ▪ Ten of the 11 individuals' PNMPs (91%) were current within the last 12 months. Individual #125's PNMP was dated 10/15/08. ▪ None of the 11 individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. o Medical staff was present in 10 of 11 annual ISP meetings (91%); o Nursing staff was present in 10 of 11 annual ISP meetings (91%); o Registered dietician staff was present in eight of 11 annual ISP meetings (73%); o Physical therapists were present in four of 11 annual ISP meetings (36%); o Occupational therapists were present in four of 11 annual ISP meetings (36%); o Speech language pathologists were present in four of 11 meetings (36%); o Psychologists were present in 10 of 11 annual ISP meetings (91%); o Dental staff were present in three of 11 annual ISP meetings (27%), and	

#	Provision	Assessment of Status	Compliance
		o Direct support professionals were present in seven of 11 meetings (64%). Per State Office policy, each individual's team should decide which team members should attend the annual meeting. However, teams at LBSSLC were just beginning to document their decisions with regard to team composition. For individuals with therapeutic needs, team will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. ▪ None of the 11 individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ Eleven of the 11 individuals' PNMPs (100%) noted individual-specific risks and related triggers. It was positive that individual-specific risks and triggers had been added to individual's PNMPs. However, individuals' PNMPs were not consistent from individual to individual. For example, high-risk PNM issues were included for some individuals, but not others. In addition, medium risk PNM issues were noted on some PNMPs, but not on others. Clarification should be provided to therapists to provide consistency for identification of individual-specific risks. ▪ Four individuals in Sample #1 were ambulatory (i.e., Individual #193, Individual #113, Individual #125, and Individual #315). In two of the remaining seven individuals' PNMPs (Individual #293 and Individual #242) (29%), adequate positioning instructions were included for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. More specifically, for the remaining individuals, the wheelchair positioning instructions did not provide adequate instructions for staff to achieve a safe elevation range. PNMP wheelchair instructions would instruct staff to place the individual in an "upright position." However, based on interview with therapists these instructions referred to the individual's body position to be most upright. The PNMP did not instruct staff on how to achieve safe elevation range in the wheelchair. ▪ In three of seven individuals' PNMPs (i.e., Individual #199, Individual #269 and Individual #167) (43%), there were adequate alternate positioning instructions, including written and pictorial instructions and safe elevation ranges. There were written and pictorial alternate positioning instructions, but instructions for how staff were to achieve a safe elevation range was missing. ▪ In seven of seven individuals' PNMPs (100%), bedtime positioning options were noted. Individual #193, Individual #113, Individual #125, and Individual #315 were able to re-position themselves in bed. ▪ In 11 of 11 individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Five individuals (i.e., Individual #193, Individual #125, Individual #242, Individual #315, and Individual #128) in Sample #1 ate orally. The following	

#	Provision	Assessment of Status	Compliance
		related findings were made with regard to these individuals' PNMPs: o Two of five individuals' dining plans (i.e., Individual #242 and Individual #315) (40%) were current in the last twelve months. o Three of five individuals' dining plans (i.e., Individual #242, Individual #315, and Individual #128) (60%) included risks and triggers. o In four of five individuals' PNMPs/dining plans (i.e., Individual #193, Individual #125, Individual #242, and Individual #315) (80%), mealtime plans included written and/or pictorial instructions for positioning. o In five of five individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for food texture. o In five of five individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In five of five individuals' PNMPs/dining plans (100%), mealtime plans included staff presentation techniques. ▪ Two of 11 individuals' PNMPs (i.e., Individual #293 and Individual #315) (18%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ Ten of 10 individuals' PNMPs (100%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. Individual #125 was not at high and/or medium risk for aspiration, respiratory compromise, or gastrointestinal problems. ▪ In one of eleven individuals' PNMPs (i.e., Individual #269) (9%), medication administration strategies included positioning options with safe elevation ranges. PNMPs were missing instructions for nursing to achieve a safe elevation range during wheelchair and/or alternate positioning options. ▪ Four individuals (i.e., Individual #193, Individual #125, Individual #242, and Individual #315) received medication orally. The following related findings were made with regard to these individuals' PNMPs: o In three of four individuals' PNMPs (Individual #193, Individual #242, and Individual #315) (75%), the medication administration strategies included instructions for diet texture and fluid consistency. o In two of four individuals' PNMPs (Individual #193 and Individual #315) (50%), the medication administration strategies included instructions for mealtime adaptive equipment. o In one of four individuals' PNMPs (i.e., Individual #193) (25%), medication administration strategies included instructions for presentation techniques.	

#	Provision	Assessment of Status	Compliance
		▪ None of 11 individuals' PNMPs (0%) included strategies for oral hygiene, including positioning with safe elevation ranges. PNMPs were missing instructions for staff to achieve a safe elevation range. ▪ Nine of 11 individuals' PNMPs (82%) included the reasons for an individual's prescribed adaptive equipment. PNMPs for Individual #113 and Individual #125 did not identify the reason for prescribed adaptive equipment. ▪ Six of 11 individuals' PNMPs (i.e., Individual #293, Individual #193, Individual #113, Individual #167, Individual #242, and Individual #128) (54%) included bathing/showering positioning instructions to achieve a safe elevation range. PNMPs were missing instructions for staff to achieve a safe elevation range. ▪ None of the seven individuals' PNMPs (0%) included adequate personal care instructions, with elevation strategies during checking and changing. As stated above, four individuals were ambulatory and did not need this type of assistance. PNMPs were missing instructions for staff to achieve a safe elevation range. ▪ Eleven of 11 individuals' PNMPs (100%) stated how an individual would communicate with staff. ▪ Six of 11 individuals' PNMPs (i.e., Individual #113, Individual #269, Individual #125, Individual #242, Individual #315, and Individual #128) (54%) included strategies for how staff was to communicate with an individual. A review of six individuals' PNMPs on the PNMT caseload (i.e., Individual #258, Individual #250, Individual #6, Individual #29, Individual #226, and Individual #12) in Sample #2 found: ▪ Six of the six individuals (100%) had a PNMP. ▪ Six of the six individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the six individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP into the ISP. o Medical staff were present in five of six annual ISP meetings (83%); o Nursing staff were present in six of six annual ISP meetings (100%); o Registered dietician staff were present in four of six annual ISP meetings (67%); o Physical therapists were present in three of six annual ISP meetings (50%). A PTA attended two of the meetings; o Occupational therapists were present in two of six annual ISP meetings (33%); o Speech language pathologists were present in two of six meetings (33%); o Psychologists were present in six of six annual ISP meetings (100%); o Dental staff were present in one of six annual ISP meetings (17%); and	

#	Provision	Assessment of Status	Compliance
		o Direct support professionals were present in three of six meetings (50%). As noted above, per State Office policy, each individual's team should decide which team members should attend the annual meeting. However, teams at LBSSLC were just beginning to document their decisions with regard to team composition. For individuals with therapeutic needs, team will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. ▪ None of the six individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ Six of six individuals' PNMPs (100%) noted individual-specific risks and related triggers. However, a review of these individuals' PNMPs showed inconsistency from individual to individual. For example, high-risk PNM issues were included for some individuals, but not others. In addition, medium risk PNM issues were noted on some PNMPs, but not on others. Clarification should be provided to therapists to provide consistency in the identification of individual-specific risks. In none of six individuals' PNMPs (0%) were there adequate positioning instructions for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. More specifically, although there were wheelchair positioning instructions, there were not adequate instructions for safe elevation range. For example, staff was instructed to place an individual in the "most upright" position, but there were not adequate instructions for placement of a safe elevation range of the wheelchair. ▪ In one of six individuals' PNMPs (i.e., Individual #250) (17%), there were adequate alternate positioning instructions, including written and pictorial instructions and safe elevation ranges. Written and pictorial instructions for the correct placement of a chain were provided for staff to achieve the prescribed head of bed elevation. However, alternate positioning instructions did not refer to the placement of the chain (i.e., right and left sidelying, supine), and did not provide adequate instructions for a safe elevation range. ▪ In six of six individuals' PNMPs (100%), bedtime positioning options were noted. ▪ In six of six individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Two individuals (i.e., Individual #12 and Individual #258) in Sample #2 ate orally. The following related findings were made with regard to these individuals' PNMPs': o One of two individuals' dining plans (i.e., Individual #12) was current in the last twelve months. o One of two individuals' dining plans (i.e., Individual #12) included risks and triggers.	

#	Provision	Assessment of Status	Compliance
		o In none of two individuals' PNMPs/dining plans (0%), mealtime plans included written and/or pictorial instructions for positioning. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for food texture. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included staff presentation techniques. ▪ None of six individuals' PNMPs (0%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ Six of six individuals' PNMPs (100%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In none of six individuals' PNMPs (0%), medication administration strategies included positioning options with safe elevation ranges. PNMPs were missing strategies for nursing staff to achieve a safe elevation range. ▪ Two individuals (i.e., Individual #12 and Individual #258) received medication by mouth. The following related findings were made with regard to these individuals' PNMPs: o In two of two individuals' PNMPs (100%), the medication administration strategies included instructions for diet texture and fluid consistency. o In two of two individuals' PNMPs (100%), the medication administration strategies included instructions for mealtime adaptive equipment. o In two of two individuals' PNMPs (100%), medication administration strategies included instructions for presentation techniques. ▪ None of the six individuals' PNMPs (0%) included strategies for oral hygiene, including positioning with safe elevation ranges. PNMPs were missing instructions on how to achieve a safe elevation range. ▪ Six of six individuals' PNMPs (100%) included the reasons for an individual's prescribed adaptive equipment. ▪ Five of six individuals' PNMPs (83%) included bathing/showering positioning instructions to achieve a safe elevation range. Individual #12's bathing instructions stated "Arjo tub with head of lift elevated." However, the instructions did not indicate how to achieve a safe elevation range. ▪ One of six individuals' PNMPs (i.e., Individual #6) (17%) included adequate personal care instructions, with elevation strategies during checking and changing. Although the remaining PNMPs included personal care instructions,	

#	Provision	Assessment of Status	Compliance
		there were not adequate instructions for safe elevation range. ▪ Six of six individuals' PNMPs (100%) included strategies for how staff was to communicate with an individual. ▪ Six of six individuals' PNMPs (100%) stated how an individual would communicate with staff. Areas of noncompliance in PNMP strategies were not significantly different between individuals in Sample #1 or Sample #2. The following concerns were noted: ▪ PNMPs were not adequate as essential components were missing. ▪ Although individuals' PNMPs had been updated to include individual-specific risks and triggers, multiple individuals' PNMPs did not include high and/or medium risks related to PNM and related triggers to alert staff to a potential change in status. ▪ Individual-specific triggers on the IRRF were not consistently transferred to the individual's PNMP. ▪ Written and pictorial instructions were provided for an individual's head of bed elevation, which demonstrated the placement of the red/green chain to achieve a safe elevation range. However, written and pictorial instructions for alternate positions (i.e., right and left sidelying) instructed staff to place an individual on their side "with elevation." Consideration should be given to expanding these instructions to include elevation per chain. ▪ Dining plans were not current within the past 12 months. ▪ HOBE assessments had not been consistently completed to establish safe elevation ranges in wheelchair and alternate positions, bathing/showering, personal care, oral care, dental appointments, or other activities that were likely to provoke swallowing difficulties. Individuals' PNMPs should have HOBE assessment data integrated to provide staff instructions for safe elevation ranges in daily activities. ▪ The absence of clinicians (i.e., OT, PT, SLP, and RD) during the annual ISP meetings negatively impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. These clinicians were the authors of the PNMPs and their contribution was critical to the team understanding the purpose of the individual's PNMP. Per State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. A general rule of having a single clinician to represent the HT Department will not suffice. This process will have to be individualized, and be driven by teams' decisions. On a positive note, the Facility had developed a PNMP Audit Tool. However, at the time	

#	Provision	Assessment of Status	Compliance
		of the review, the tool had not been implemented. The Facility should ensure the audit tool encompasses the preceding PNMP essential components. **Implementation of Individuals' PNMP Off-Campus (i.e., community outing, hospitalization)** The State Office policy 012.2 stated that PNMPs were to "span a 24-hour day, 7 days a week." On a positive note, the Monitoring Team's observation during the morning provider meeting and review of documentation the Hospital Liaison Nurse presented indicated the presence of an individual's PNMP and correct positioning during hospitalization. Since the last review, nine individuals in Sample #1 (i.e., Individual #293, Individual #199, Individual #193, Individual #74, Individual #113, Individual #269, Individual #167, Individual #242, and Individual #128) and four individuals in Sample #2 (i.e., Individual #258, Individual #250, Individual #29, and Individual #12) been hospitalized. The Monitoring Team reviewed Hospital Liaison Reports for three individuals in Sample #1 (i.e., Individual #293, Individual #113, and Individual #128) and two individuals in Sample #2 (i.e., Individual #258 and Individual #12). A review of Hospital Liaison reports for three individuals in Sample #1 noted the following: ▪ None of the Hospital Liaison Reports for Individual #113, and Individual #128, and Individual #293 (0%) addressed the presence and/or implementation of the individual's PNMP. A review of Hospital Liaison Reports for two individuals in Sample #2 found: ▪ None of the Hospital Liaison Reports for Individual #258 and Individual #12 (0%) addressed the presence and/or implementation of the individual's PNMP. These were examples of individuals' PNMPs not being monitored for implementation while off-campus. The implementation of PNMPs in the hospital should be of highest priority. The Facility should ensure the implementation of PNMPs off-campus, including community outings, transportation to the emergency room, and monitoring responsibility for staff compliance. **Change in Status Update for Individuals' PNMPs Conducted by the IDT and/or Individuals on the PNMT Caseload** Individuals' revised PNMPs were reviewed to determine if an ISPA meeting had been conducted to address the proposed revisions. For the individuals in Sample #1, nine of the 11 individuals' PNMPs had been revised after their annual ISP meeting (i.e.,	

#	Provision	Assessment of Status	Compliance
		Individual #199, Individual #193, Individual #74, Individual #113, Individual #269, Individual #167, Individual #242, Individual #315, and Individual #128). ▪ Two of the nine individuals (i.e., Individual #167 and Individual #269) (22%) had an ISPA meeting conducted to discuss and approve PNMP revisions. ▪ Six of the nine individuals' records (i.e., Individual #242, Individual #269, Individual #193, Individual #128, Individual #315, and Individual #199) (67%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., individual-specific monitoring). When revisions occur to a PNMP, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. For the individuals in Sample #2, six of the six individuals' PNMPs (i.e., Individual #258, Individual #250, Individual #6, Individual #29, Individual #226, and Individual #12) had been revised after their annual ISP meeting. ▪ Six of the six individuals had an ISPA meeting (100%) to discuss and approve PNMP revisions. ▪ Six of the six individuals' records (100%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., IPN notes, individual-specific monitoring).	
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.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** The Monitoring Team and members of the PNMT (i.e., PNMT Nurse and PTA) completed direct observations in residences for four individuals on the PNMT caseload, including: Individual #258, Individual #6, Individual #226, Individual #12, and Individual #89. These observations found: ▪ In three of the three observations (100%), individuals' staff on first shift were following PNMP instructions for alternate positioning (i.e., Individual #226, Individual #258, and Individual #6). ▪ In none of the two observations (0%) was staff on second shift following the PNMP for alternate positioning (i.e., Individual #258 and Individual #226). ▪ In none of one observation of a mechanical lift transfer (0%) were staff following the transfer instructions (i.e., Individual #89). ▪ In none of the one observation during bathing (0%) was staff consistently following the PNMP for bathing instructions (i.e., Individual #89). ▪ In none of the one mealtime observation (0%) were staff following the dining plan (i.e., Individual #12) ▪ In one of the two observations of an individual during medication administration (50%) (i.e., Individual #6) was the nurse following the PNMP instructions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		On a positive note, observations completed in 504E and 504W noted that staff on first shift was competent in their implementation of individuals' PNMPs for wheelchair and/or alternate positioning. However, observations completed during second shift in these homes noted that staff was not competent in the implementation of individuals' PNMPs. The PNMP provides the foundation for health and safety. These observations substantiated that some staff were not competent and/or compliant in implementing foundational and/or individual-specific PNMP strategies. The PNMT and IDT members should provide additional support to staff to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk. The Facility's efforts to train staff and monitor their compliance with PNMPs are discussed below with regard to Sections O.5 and O.6. The full implementation of adequate training and monitoring activities is key to ensuring "staff engage in mealtime practices that do not pose an undue risk of harm to any individual."	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**NEO Orientation** The Facility Physical Therapists, Occupational Therapists, and Speech Language Pathologists provided training for new employees. On a positive note, new employee training for PNM had been increased by six and one-half hours for a total of 13.5 hours of instruction. Based on information the Facility provided, since the Monitoring Team's last review, 169 of 169 new employees (100%) successfully completed NEO PNM training. **PNM Core Competencies for Current Staff** Based in interview with the Director of HT, a final plan had not been developed to provide training in foundational PNM competencies to current staff. This was problematic. **Annual Refresher Training** Based on interview, the Facility's annual refresher training included two courses: Lifting People, and Preventing Aspiration. The Facility reported that 437 of 458 staff (95%) had completed the two annual refresher courses. The Facility should consider expanding Annual Refresher training to include testing of core competencies for mealtimes. **Individual Specific Training** Based on record review, individuals' staff in Sample #1 had received PNMP individual-specific training, which was positive. However, no data had been compiled into a tracking system for PNMP individual-specific performance check-offs. Consequently, it was not possible to determine how many staff had successfully completed individual-specific performance check-offs (n) versus the total number of staff (N) needing to	Noncompliance

#	Provision	Assessment of Status	Compliance
		complete PNMP individual-specific training and performance check-offs. Eleven of the eleven individuals in Sample #1 had their PNMPs revised. It was positive that PNMP individual-specific training and performance check-offs had been completed for some of the changes to individuals' PNMPs. However, as stated in the last report, individual-specific performance check-offs did not require staff demonstration. This practice continued in the competency check-offs reviewed for individuals in Sample #1. Written tests without a demonstration component did not meet the standard of competency-based training for the required skills or competencies for PNMP implementation. The following examples provide additional information: ▪ Individual #199's staff answered three questions for his PNMP and Pleasure Feeding Plan, including Risks and Triggers. This test did not require staff to demonstrate their skills for the implementation of his dining plan. In addition, there were individual-specific written and pictorial instructions for supine positioning, right sidelying, and bed elevation. There were no performance check-offs completed by staff for these PNMP strategies. • Temporary PNMP competency training for Individual #113 required staff to answer questions to identify his risks, assistive equipment, use of a seatbelt, identify how he was to bathe, and how much assistance was required for him to safely walk. Staff was not required to demonstrate how to safely assist him to walk. The Facility should review individual-specific check-offs to ensure these check-offs require staff demonstration of PNMP strategies. In addition, these examples reinforce the importance of finalizing and implementing the PNM foundational training plan and completion of performance check-offs for veteran staff to test their competency for PNMP implementation. **<u>Training of Relief/Pulled Staff</u>** The Facility policies entitled Ensuring Training of Pulled Staff/Transfer Staff, revised 5/20/09, and Staff Coverage with Pulled Staff, revised 8/25/08, stated: "the pull staff must demonstrate verbal competency on the number items on the PBSP sections regarding Prevention and How to Respond to Challenging Behaviors before they are allowed to accept their assigned group." However, the policy did not address staff competencies with the implementation of PNMPs. At the time of the onsite review, current staff had not completed training and performance check-offs in core PNM competencies. Observations completed by the Monitoring Team substantiated that current and/or relief/pulled staff that provided supports to individuals on the PNMT caseload required additional support to implement PNMPs correctly. **<u>Trainer Competencies</u>**	

#	Provision	Assessment of Status	Compliance
		PNMP Coordinators were responsible for training staff on PNMP individual-specific competency-based training and performance check-offs. Based on interview, the Facility had not formalized a train-the-trainer process for the PNMP Coordinators. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers. **Facility Initiatives** The Monitoring Team met with representative members of the Mealtime Improvement Committee (MIC) (i.e., Assistant Director of Programs, Unit Director, and Safety Representative) for an update on what the committee had accomplished since the last review. The Director of HT also attended the meeting. The following accomplishments had been completed: ▪ 32 of 57 Meal Time Coordinators (MTCs) (56%) had successfully completed competency-based training and performance check-offs; ▪ A written plan had been established for MTCs who failed the first competency performance check-off. If the MTC failed the first test, another check-off would be completed. Prior to the second check-off, the trainer would create and implement a training plan. If the MTC failed the second check-off, the Residential Coordinator of the home was informed they had one week to work with the MTC. At the end of the week, a third check-off would be completed. If the MTC failed the third check-off, a review board would be created from MTC committee members including the Residential Coordinator and MTC. An action plan was to be developed to meet the MTC's needs. ▪ Home Plans were developed to assist MTCs in supporting a safe mealtime environment. For example, the Home Procedure for Rose provided procedures to be followed before the meal: what should be set up, the number of staff and individuals to be present at a table, adjustment of table heights; and during the meal: suggestions on the order of individuals entering the dining room and evaluation of dining style based on preference and functional skills assessments. ▪ Table Captains were staff designated by the MTC to assist and support individuals at dining room tables. The Table Captain was the main support for individuals during mealtime and responsible for the application of all mealtime strategies (i.e., Dining Plan, skill acquisition programs, and food and fluid sheets). The goals for the MTC over the next three months were completion of competency performance check-offs, initiation of re-evaluation of MTCs, and retaining the current MTC members.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three	**Facility Monitoring of Staff Competency with PNMPs** The primary monitoring form the HT Department staff used was the Compliance Monitoring form. The Compliance Monitoring tool had been reinitiated on 8/16/12. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	PTs, PTA, OTs, RDs, and SLPs were responsible for monitoring. However, at the time of the review, no Facility protocols had been developed for the implementation of the monitoring process. There was no established schedule and/or process to monitor individuals at high risk. A spreadsheet was submitted that included the following fields: monitor focus (e.g., positioning), monitor type (e.g., individual specific), date, location, home, individual's name, and observer name and title. Monitoring had been completed for positioning, bathing, communication, lifting/transfer, and meals. However, as noted above, there was no established monitoring schedule and/or an established frequency to monitor individuals at high risk. On a positive note, the HT Department staff had developed a monitoring database. It included adequate indicators to provide data to track and trend monitoring data. However, no reports had been generated to track and trend monitoring results. The Monitoring Team reviewed the monitoring results for four individuals (i.e., Individual #258, Individual #6, Individual #226, and Individual #12) in Sample #2 who the Monitoring Team and members of the PNMT observed. However, the Facility monitoring results were not congruent with some of the observations conducted during the onsite review. The Monitoring Team requested individual-specific monitoring results for the past six months. The monitoring results were reviewed and the following concerns were noted: ▪ A Registered Dietician monitored Individual #258's staff for their compliance with his positioning. Individual #258 was monitored one time over the past six months. No monitoring was conducted for oral care, mealtimes, snacks, bathing, lifting/transfers, wheelchair and/or alternate positioning, medication administration, communication, and/or programming. ▪ The Compliance Monitoring form for Individual #6's staff was completed four times over the past six months (i.e. once in May and three times in July). The monitors were a RD, PTA, and OT. Three of the monitoring forms were scored at 100% and one was scored at 88%. No compliance monitoring was conducted for medication administration, oral care, bathing, lifting/transfer, and/or communication. ▪ No Compliance Monitoring forms were submitted for Individual #226. ▪ A RD monitored Individual #12's staff one time during the past six months. Positioning was monitored. The compliance score was 88%. No compliance monitoring was performed for medication administration, oral care, bathing, lifting/transfer, and/or communication. The monitoring data for these individuals reflected 88% to 100% staff compliance with PNMPs. The Facility's monitoring results were not in alignment with some of the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team's observations. Consequently, the Monitoring Team did not have confidence in the individual-specific monitoring data presented. These monitoring results would lead the Facility to the conclusion that there were no problems with staff compliance with PNMPs. However, the Monitoring Team and members of the PNMT observed breaches in the implementation of individuals' PNMPs for the four individuals observed. These monitoring results would not be useful in identifying problematic trends that needed to be addressed. The Facility should be able to have confidence in monitoring data to allow it to substantiate identified problematic trends, and, as a result, develop corrective action plans to address the trends. In addition, no evidence was presented to confirm inter-rater reliability between monitors. Inter-rater reliability should be established for the monitoring tools to ensure that all auditors/monitors are consistently determining compliance using the same process and criteria. As stated in previous reports, the HT Department staff 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 by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific 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.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two	**Effectiveness of Monitoring to Assess the Progress of Individuals with Physical or Nutritional Management Difficulties** The State At-Risk Individuals policy in the Risk Review section indicated: "each discipline	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	or program staff identified as responsible in the plan must review the support plans that address identified risk to assess the effectiveness of the support for which they are responsible. This review must be completed as indicated by an individual's risk severity or status change, in order to assess effectiveness. Documentation of the review will be recorded in the Integrated Progress Notes." To achieve compliance within this provision, members of the IDT and/or PNMT should conduct effectiveness monitoring. Effectiveness monitoring should not be confused with compliance monitoring. A compliance monitoring system, as required in Section O.6, provides information on the status of staff compliance with PNMPs. The purpose of effectiveness monitoring is to report on the efficacy of the interventions developed to minimize and/or reduce high and/or medium PNM risk indicators. Effectiveness monitoring should answer the question of whether the individual is better or worse. A review of individuals' Risk Action Plans, Integrated Health Care Plans, and IPNs in Sample #1 found: ▪ None of the 11 individuals' records (0%) contained evidence of effectiveness monitoring by therapists to assess the efficacy of risk action plan interventions for individuals with PNM difficulties. ▪ None of the 11 individuals' records (0%) contained evidence that interventions were changed due to a lack of an individual's progress. The following concerns were noted: ▪ IDT members had not conducted effectiveness monitoring to assess the progress of an individual's risk action plan interventions. ▪ Individuals' Risk Action Plans did not generate individual-specific clinical data, which should be used to substantiate an individual progress and to assess if the individual was better or worse. ▪ Individuals' IPNs did not include assessment an individual's clinical indicators to provide an update on health stability and/or instability. ▪ Monthly progress reports were not completed to report on the effectiveness of an individual's supports and services as identified in the risk action plans. **<u>PNMT Monitoring to Assess Individuals' Progress</u>** The Facility PNMT Guidelines discussed effectiveness monitoring responsibilities as follows: ▪ Monitor and reassess the resident's health status until the resident is determined to be stable or at lower risk, if appropriate (i.e., Purpose of the PNMT); ▪ Performing interventions and monitoring as assigned (i.e., Responsibilities of PNMT Member);	

#	Provision	Assessment of Status	Compliance
		▪ Training staff and monitors in expected responsibilities and outcomes (i.e., Responsibilities of PNMT Member); ▪ Monitoring implementation of recommendations by the IDT (i.e., Responsibilities of PNMT Nurse); and ▪ Periodic re-evaluation of effectiveness/completion of recommendations (i.e., Responsibilities of Dietician, OT, PT and SLP). Based on the Monitoring Team's review of the records for individuals in Sample #2: ▪ None of the six individuals' records (0%) contained evidence that the progress of individuals with PNM difficulties was monitored to assess the efficacy of the risk plan interventions. ▪ None of the six individuals' records (0%) contained evidence that interventions were changed due to a lack of progress. The following concerns were noted: ▪ Individual-specific triggers had not been integrated into Aspiration Trigger Data Sheet(s) to alert staff to a change in status. Aspiration Trigger Data sheets were not consistently completed. ▪ Individuals' PNMT action plans did not consistently specify individual-specific clinical indicators to define an individual's stable and/or unstable health status. Individuals' PNMT Follow-up and IPNs consistently stated that the PNMT was conducting monitoring of IPNs and trigger sheets. However, these monitoring results were not definitive in reporting if the data obtained during an assessment showed the individual's health status was stable and/or unstable. In addition, the monitoring results did not address the efficacy of the recommended interventions to minimize the individual's PNM risks. ▪ Individuals did not receive individual-specific effectiveness monitoring. ▪ IPNs did not include a report on the effectiveness of an individual's supports and services as identified in a risk action plan. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions, as appropriate.	
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	**Individuals Who Receive Enteral Nourishment** Based on interview with the Director of HT, the Chief Dietician was responsible for maintaining and updating the list of individuals who received enteral nutrition. However, there was no Facility policy and/or procedure(s) to formalize a system to maintain and update this list. Due to the concerns with the lists noted below, the Facility should develop and implement procedures to maintain and update the list of individuals who receive enteral nutrition.	Noncompliance

#	Provision	Assessment of Status	Compliance
	use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Two lists were submitted that identified individuals who received enteral nutrition: ▪ LBSSLC Individuals on Enteral Feedings, not dated, identified 46 individuals who were fed by tube. The list reported the name of the individual, their home case number, formula, feeding site (e.g., gastrostomy tube), frequency of feeding, and enteral feeding initiation/discontinuation date. However, the enteral feeding initiation/discontinuation date column was blank. ▪ Individuals Who Receive Enteral Feedings, not dated, identified 11 individuals. Consequently, there was a discrepancy in how the Facility calculated the number of individuals who received enteral nutrition. The Facility should maintain an accurate accounting of individuals who receive enteral nutrition. **Individual(s) Who Received a Feeding Tube** The Facility PNMT Guidelines, revised August 2012, indicated that the IDT, PCP, and/or the PNMT may refer individuals identified as being at a specific high risk for which the IDT requires assistance/specialized services. The Guidelines did not specifically address a referral to the PNMT when the IDT was giving consideration to initiate enteral feeding for an individual. However, the PNMT Episode Tracker system stated that new and/or proposed enteral nutrition would be a threshold for referral to the PNMT. Since the last review, Individual #113 had received a feeding tube. However, Individual #113 had not been referred to the PNMT prior to placement of the tube to address his nutritional decline that resulted in the placement of a feeding tube. The Facility should revise the Facility PNMT Guidelines to define the clinical nutritional indicators that place an individual at risk of receiving a feeding tube. When an individual experiences an ongoing nutritional decline, the IDT should refer the individual at risk of receiving a tube to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement. **APEN Data Sheet and Integrated Risk Rating Form** Since the Monitoring Team's last review, the draft State At-Risk Individuals policy and procedures, dated 5/24/12, presented a revised process for completing an APEN data sheet, as opposed to the previous assessment. The Aspiration Pneumonia/Enteral Nutrition (APEN) was identified as a data collection tool that should be completed at least annually if the individual: ▪ Had aspiration pneumonia during the past year; and/or ▪ Received enteral nutrition or medication. The Change of Status IRRF noted: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish	

#	Provision	Assessment of Status	Compliance
		medical necessity of continuing enteral nutrition. The analysis and related rational must be documented in the IRRF." The APEN Data Sheet instructions also indicated: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish medical necessity of continuing enteral nutrition." The analysis and related rationale was to be documented in the individual's Integrated Risk Rating Form. The purpose of the APEN was to "provide a vehicle for recording the data needed to guide the team in determining appropriate risk assignment." Multiple disciplines were to contribute APEN data. The Nurse Case Manager was responsible for bringing the completed form to the ISP meeting. The IDT would utilize the APEN data for a "comprehensive discussion of enteral nutrition, aspiration and other related risk factors." The IDT was to "formulate plans based on the discussion and analysis to determine the best course of treatment or action for individuals who have had aspiration pneumonia and to assess individuals for possible return to oral eating." However, these revisions had not been formally implemented. The LBSSLC Provision Action Information Update acknowledged the initiation of the APEN data sheet on 8/20/12. Based on interview with the Section I Lead, blank copies of the revised IRRF and APEN were placed in a shared drive folder to ensure they were accessible to the IDT members. The APEN data sheet was to be completed 10 working days prior to the annual ISP meeting. At the time of the review, the Facility had not yet made this revision for all individuals. At the time of the review, the Facility had not completed audits of APEN data sheets and IRRFs to assess their compliance with established guidelines. The Facility list(s) of individuals who received enteral nutrition did not indicate the date of the most current APEN data sheet. The Facility list(s) should include the date of the APEN data sheet, IRRF, and ISP, including confirmation of the required discussion and team decision, to track whether or not data is collected and team assessments are conducted at least annually to determine whether or not the continued use of the feeding tube is medically necessary. Eight individuals in Sample #1 received enteral nourishment, including: Individual #293, Individual #199, Individual #74, Individual #113, Individual #269, Individual #167, Individual #242, and Individual #128. Five of the eight individuals (75%) did not have an APEN assessment and/or data collection tool completed (due to the timing of the review, the old APEN assessment as well as the APEN data collection tools were requested), including: Individual #242, Individual #269, Individual #167, Individual #199, and Individual #74. A review of the remaining three individuals' (i.e., Individual	

#	Provision	Assessment of Status	Compliance
		#113, Individual #128, and Individual #293) APEN assessments (i.e., for these individuals, the new APEN data sheet was not in use yet), action plans, and ISPs found: ▪ None of the three individuals' APEN assessments and IRRFs (0%) followed the State-established APEN template. ▪ One of the three individuals' APEN assessments and IRRFs (i.e., Individual #293) (33%) was completed within a 12-month period. ▪ One of the three individuals' APEN assessment and IRRFs (i.e., Individual #293) (33%) indicated that there was input from appropriate IDT members as outlined in the State-established APEN format. ▪ None of the three individuals' APEN assessments and IRRFs (0%) provided justification that the continued use of the tube was medically necessary. The assessment, or moving forward, the IRRF or ISP, should provide clinical justification and an analysis of why the tube remains a medical necessity. The assessment did not assess the medical necessity of a tube or assess the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate. ▪ None of the three individuals' APEN assessment and IRRF recommendations or action plans (0%) was implemented. ▪ None of the three individuals' APEN assessments and IRRFs (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. Four individuals in Sample #2 received enteral nourishment, including: Individual #250, Individual #6, Individual #29, and Individual #226. Individual #250 had received a feeding tube in May 2012 and an APEN assessment had not been completed. A review of three individuals' APEN assessments (i.e., for these individuals, the new APEN Data Sheet was not in use yet), action plans, and ISPs found: ▪ None of the three individuals' APEN assessments and IRRFs (0%) followed the State-established APEN data sheet template. ▪ Three of the three individuals' APEN assessments and IRRFs (100%) were completed within a 12-month period. ▪ Two of the three individuals' APEN assessments and IRRFs (i.e., Individual #226 and Individual #258) (67%) indicated that there was input from appropriate IDT members as outlined in the State-established APEN template. ▪ Two of the three individuals' APEN assessments and IRRFs (i.e., Individual #226 and Individual #29) (67%) provided justification that the continued use of the tube was medically necessary. ▪ None of the three individuals' APEN recommendations and action plans (0%) was implemented. ▪ None of the three individuals' APEN assessments and IRRFs (0%) recommended the implementation of a plan to return the individual to oral feeding, if	

#	Provision	Assessment of Status	Compliance
		appropriate. On a positive note, there was a discernible difference between APEN assessments completed for individuals supported by the PNMT. However, these assessments and action plans for individuals in Sample #1 and one individual in Sample #2 did not meet the requirements of the Settlement Agreement to: "evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary" and "where appropriate, the Facility shall implement a plan to return the individual to oral feeding." **Pathway to Return to Oral Eating and/or Receive a Less Restrictive Approach to Enteral Nutrition** Based on interview with the Director of HT, the Facility did not have written procedures for returning an individual to a less restrictive approach to receiving enteral nutrition or, if appropriate, a return to oral eating. None of the individuals in Sample #2 participated in a formal therapeutic/pleasure feeding program. Two individuals in Sample #1 participated in oral eating (i.e., Individual #199 and Individual #128). A review of these individual's records found: ▪ None of the two individuals who had returned to oral eating (0%) had a plan to return to oral feeding. ▪ Because no plan had been developed, its implementation could not be assessed. ▪ None of the two individuals who returned to oral eating (0%) had received a mealtime assessment. ▪ Because no plan existed, none of the two individuals' plans (0%) identified individual-specific triggers for when the plan should be stopped. ▪ Because no plan existed, none of the two individuals' plan (0%) identified monitoring oversight for staff compliance with the plan. ▪ Because no plan existed, none of the two individuals' plans (0%) were monitored as outlined in the plan. ▪ Because no plan existed, none of the two individuals' plans (0%) were modified, if appropriate. The Facility should establish procedures for IDTs and/or PNMT members to follow for individuals who were recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake.	

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

1. The HT Director should initiate an analysis of the current clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators), as well as the various duties of clinicians

to determine if the current staffing as well as the caseload distribution is adequate and appropriate. (Section O.1)

2. The PNMT Coordinator should ensure representation of PNMT members during meetings. (Section O.1)
3. The Facility should provide training for IDT members on the Facility PNMT Guidelines to ensure IDT members understand the role and responsibilities of the PNMT, as well as their role and responsibilities in reference to the PNMT. (Section O.1)
4. Lists the Facility maintains to identify individuals having physical and nutritional management problems should be accurate. The Facility should develop and implement a sustainable system to maintain and update these lists to ensure their validity. (Section O.2)
5. The Facility Health Status List should include individuals' risk ranking for infections. (Section O.2)
6. PNMT assessments should be sufficient to identify physical and nutritional interventions and supports to meet the individuals' needs. They should follow the Facility-established PNMT assessment template; provide an adequate analysis to identify the cause of the individual's PNM concerns; include a PNMT self-referral and/or IDT referral date; update the individual's risk rating(s), as appropriate; address HOBE assessment data; establish individual-specific clinical baseline data to assist teams in recognizing changes in health status; and identify individual-specific clinical criteria to alert nursing staff to contact the PNMT. (Section O.2)
7. PNMT action plans should include: the individual's identified PNM problems as presented in the PNMT assessment; integration of HOBE assessment data; preventative interventions to minimize the conditions of identified risk indicators; appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan; and specific clinical indicators to be monitored. (Section O.2)
8. The HT Department should follow the State Office policy for individuals who require a PNMP. The State Office policy should be utilized to review the Facility's list of individuals who have do not have PNMPs to determine which of these individuals meet the PNM criteria, and provide them with a PNMP sufficient to meet their needs. (Section O.3)
9. The Facility should ensure the implementation of PNMPs off-campus. (Section O.3)
10. The Facility should review the PNMP audit tool to ensure the tool includes the essential components of PNMPs reviewed in this report. (Section O.3)
11. The Facility should implement the PNMP audit tool to ensure individuals' PNMPs contain essential components. (Section O.3)
12. When revisions to PNMPs occur, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. (Section O.3)
13. The attendance of only one therapy professional at an annual ISP meeting should be reevaluated. Per State Office policy, each individuals' team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. (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 PNMT and IDT members should provide additional training and/or support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. (Section O.4)
17. The provision of competency-based training and staff performance check-offs for PNM core competencies for veteran staff should be implemented. (Section O.5)
18. The Facility should review competency-based individual-specific training and performance check-offs for PNMP strategies to ensure the performance check-offs require a demonstration component. (Section O.5)
19. 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)
20. The Facility should provide additional training and/or support to relief/pulled staff to ensure PNMPs are implemented as prescribed. (Section O.5)

21. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers. (Section O.5)
22. As recommended in previous reports, the HT Department staff 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 by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement;
    c. Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific 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 and 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 implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions as appropriate. (Section O.7)
25. The Facility should develop a sustainable system to maintain and update an accurate list(s) of individuals who receive enteral nutrition. (Section O.8)
26. The Facility list(s) identifying individuals who receive enteral nutrition should include the date of the APEN data sheet, IRFF, and ISP, including confirmation of the required discussion and team decision, to track whether or not data is collected and team assessments are conducted at least annually to determine whether or not the continued use of the feeding tube is medically necessary, as required by the Settlement Agreement. (Section O.8)
27. The Facility should establish procedures for IDTs and/or PNMT members to follow individuals recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake. (Section O.8)

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 Self-Assessment, Action Plans, and Provision Action Information for Section P; o For the following eight individuals, including individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s): Individual #43, Individual #210, Individual #192, Individual #322, Individual #161, Individual #324, Individual #34, and Individual #156, the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o Facility policies and procedures related to the provision of OT/PT supports and services implemented since the Monitoring Team's last visit; o Organizational chart of Habilitation Therapy Department; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Continuing education completed by OTs and PTs, since the Monitoring Team's last onsite visit; o List of individuals who use wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices;

	○ List of individuals with orthotics and/or braces; ○ Physical Nutritional Management Maintenance Log; ○ OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; ○ Completed OT/PT Assessments for newly admitted individuals since the Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Individual-specific mealtime monitoring schedule; ○ Monthly individual-specific PNMP check sheet; ○ Monthly Home Equipment check sheet; ○ Compliance Monitoring form template; ○ PNMP Clinic minutes; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ Summary reports and monitoring results related to OT/PT; and ○ List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: ○ Linda Thomas, Director of Habilitation Therapy, OT; ○ Denise Juarez, OT; ○ Stephanie Hernandez, OT; ○ Jon Olive, PT; ○ Jennifer Cunningham, PT; and ○ Melissa Olive, PTA. ▪ **Observations of**: ○ Residences 504W, 504E, 513, and 527.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section P, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/ guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Compliance Monitoring tool. The HT Department and/or QA/QI staff were not using the Monitoring Tool for Section P. Based on interview, the Director of HT was in the process of revising the Monitoring Tool for Section P. ○ This monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Compliance Monitoring tool was designed to monitor staff compliance with PNMPs, including positioning, mealtime,

	snacks, medication administration, oral care, bathing, and lifting/transfers. This tool was not adequate to provide sufficient data to address the provisions of all of the subsections of Section P. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The Compliance Monitoring tool did not have adequate methodologies to substantiate compliance for the subsections of Section R. o The Self-Assessment did identify the sample(s) sizes. Individuals selected for the sample were individuals at high risk for falls, fractures, osteoporosis, and skin integrity. Random samples were derived from individuals' risk reports. The Facility will need to clearly identify the total population (N) used to define the sample selected (n). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility's revision to the monitoring tool for Section P should provide adequate written procedures for the implementation of the monitoring tool. o The following staff/positions were responsible for completing the audit tools: Program Compliance Monitor. The HT Department monitoring was deferred due to a shortage of therapists. When the revised monitoring tool is implemented, the therapists should monitor with the Program Compliance Monitor, and inter-rater agreement should be established. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed staff training rosters. However, additional indicators could be developed, particularly in relation to outcomes for individuals. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section P. This was consistent with the Monitoring Team's findings ▪ The Facility data did identify areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: Individuals' OT/PT assessments were significantly improved from the last review. However, the assessments were still missing some essential components. A positive practice was the development of an OT/PT assessment audit tool, but the tool had not been implemented.

	OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports. Individuals with PNMPs and dining plans were not monitored at an established frequency with an emphasis on enhanced monitoring for individuals at high risk for PNM concerns. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability, and effectiveness.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.</td><td><u>Current Staffing</u>
The Facility had five OT and three PT positions allocated. At the time of the review, there were two full-time OTs and three OT vacancies. There were two full-time PTs and a full-time contract PT was scheduled to begin work on October 15, 2012.

Based on the documentation provided, the combined OT caseload total was for 226 individuals. This exceeded the census of 211 individuals at the time of the review. The combined PT caseload was for 189 individuals. The OT/PT caseloads had not been readjusted to reflect the current OTs and PTs on staff at the time of the review. Based on this somewhat outdated information, the following chart represents the caseload of the Facility OTs and PTs including current therapy vacancies:

<table>
<tr><th>Occupational Therapists</th><th>Current Caseload</th></tr>
<tr><td>OT #1</td><td>Assigned 32 individuals, but had resigned</td></tr>
<tr><td>OT #2</td><td>Assigned 97 individuals, but had resigned</td></tr>
<tr><td>OT #3</td><td>Supported 97 individuals</td></tr>
<tr><td>OT #4</td><td>Supported 57 individuals with the assistance of other OTs</td></tr>
<tr><td>OT #5</td><td>Vacant position</td></tr>
<tr><th>Physical Therapists</th><th>Current Caseload</th></tr>
<tr><td>PT #1</td><td>Supported 18 individuals on the PNMT caseload and an additional 96 individuals</td></tr>
<tr><td>PT #2</td><td>Supported 122 individuals</td></tr>
<tr><td>PT #3</td><td>Contract PT scheduled to begin full-time on 10/15/12</td></tr>
</table>

Each of these therapists held a license to practice in the state of Texas.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The Facility did not indicate what an adequate caseload for OTs and PTs at Lubbock SSLC would be. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to OT and PT needs. **<u>Continuing Education</u>** Documentation of continuing education courses the OTs and PTs completed was submitted. Clinicians attended the following continuing education courses: ▪ Ethics and Your Professional Responsibilities; ▪ Sensory-Based Strategies for Community, Home, and School; ▪ Taming the Social Context Jungle; ▪ Transition Planning is a Strength-Based Process; ▪ I'm Not the Only One! Developing Community-Based Social Skills Groups and Camps; ▪ Safety in the Community and Beyond; ▪ Risk Training provided by the State Office; ▪ Addressing Feeding Issues for Students with Autism Spectrum Disorder; ▪ Grinbath Eye Guide Assist; and ▪ Anatomy of Swallowing. Attendance sheets, course curriculum, and continuing education certificates of completion were submitted for these courses. Three OTs, two PTs, and a PTA attended appropriate continuing education courses that included information that was relevant to and transferrable to the individuals they supported. **<u>New Admissions</u>** Three individuals (i.e., Individual #30, Individual #27, and Individual #40) had been admitted to LBSSLC since the last review. An examination of their admission and OT/PT assessment dates showed: ▪ Three of three individuals (100%) received an OT/PT assessment within 30 days of admission or readmission. **<u>OT/PT Assessments</u>** An OT/PT assessment should include the following essential components: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed at least 10 days prior to the annual ISP meeting; ▪ Diagnoses and relevance to functional status; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to functional status; ▪ Health status over the last year; ▪ Medications and potential side effects relevant to functional status;	

#	Provision	Assessment of Status	Compliance
		▪ Documentation of how the individual's risk levels impact his/her performance of functional skills; ▪ Functional description of motor skills and activities of daily living with examples of how these skills are utilized throughout the day; ▪ Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work); ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new functional skills; ▪ Comparative analysis of health and impact on functional status over the last year; ▪ Comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Identification of need for direct or indirect OT and/or PT services, as appropriate; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Eight individuals' OT/PT comprehensive assessments (i.e., Individual #43, Individual #210, Individual #192, Individual #322, Individual #161, Individual #324, Individual #34, and Individual #156) were reviewed for the presence of the essential components of an assessment. This review found: ▪ Eight of eight individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Five of seven individuals' OT/PT assessments (i.e., Individual #43, Individual #192, Individual #322, Individual #161, and Individual #156) (71%) were dated as having been completed at least 10 days prior to the annual ISP. The ISP submitted for Individual #34's was not current (i.e., 3/22/11). Consequently, the Monitoring Team could not determine if the OT/PT assessment, dated 3/16/12, had been completed at least 10 days prior to the annual ISP; ▪ Eight of eight individuals' OT/PT assessments (100%) included diagnoses and relevance to functional status; ▪ One of eight individuals' OT/PT assessments (i.e., Individual #43) (13%)	

#	Provision	Assessment of Status	Compliance
		included individual preferences, strengths, and needs; ▪ Seven of eight individuals' OT/PT assessments (i.e., Individual #43, Individual #210, Individual #192, Individual #322, Individual #161, Individual #324, and Individual #156) (87%) included medical history and relevance to functional status; ▪ Seven of eight individuals' OT/PT assessments (i.e., Individual #43, Individual #210, Individual #192, Individual #322, Individual #161, Individual #324 and Individual #156) (88%) addressed health status over the last year; ▪ None of eight individuals' OT/PT assessments (0%) listed medications and discussed the potential side effects relevant to functional status; ▪ Six of eight individuals' OT/PT assessments (i.e., Individual #43, Individual #192, Individual #322, Individual #161, Individual #324, and Individual #156) (75%) provided documentation of how the individuals' risk levels impacted their performance of functional skills; ▪ Eight of eight individuals' OT/PT assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day; ▪ Six of eight individuals' OT/PT assessments (i.e., Individual #192, Individual #322, Individual #161, Individual #324, Individual #34, and Individual #156) (75%) provided evidence of observations by OTs and PTs in the individuals' natural environments (e.g., day program, home, work); ▪ None of eight individuals' OT/PT assessments (0%) reviewed the current supports and services provided throughout the last year and their effectiveness, including monitoring findings; ▪ Two of eight individuals' OT/PT assessments (i.e., Individual #43 and Individual #192) (25%) discussed the expansion of the individual's current abilities; ▪ Two of eight individuals' OT/PT assessments (i.e., Individual #43 and Individual #192) (25%) presented the individual's potential to develop new functional skills; ▪ Seven of eight individuals' OT/PT assessments (i.e., Individual #43, Individual #210, Individual #192, Individual #322, Individual #161, Individual #324, and Individual #156) (88%) gave a comparative analysis of health and impact on functional status over the last year; ▪ Three of eight individuals' OT/PT assessments (i.e., Individual #192, Individual #322, and Individual #161) (38%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Eight of eight individuals' OT/PT assessments (100%) identified the need for direct or indirect OT and/or PT services, as appropriate, or justified the rationale for not providing it; ▪ Eight of eight individuals' OT/PT assessments (100%) had a reassessment	

#	Provision	Assessment of Status	Compliance
		schedule; ▪ None of eight individuals' OT/PT assessments (0%) supplied a monitoring schedule; ▪ Two of eight individuals' OT/PT assessments (i.e., Individual #43 and Individual #192) (25%) had recommendations for direct interventions and/or skill acquisition programs; ▪ Eight of eight individuals' OT/PT assessments (100%) made a recommendation about the appropriateness for community transition. ▪ Eight of eight individuals' OT/PT assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Individual's OT/PT assessments were significantly improved from the last review. However, the assessments still were missing some essential components as noted above. Consequently, these assessments were not yet adequate. The OTs and PTs should consider the essential components that were not present when completing assessments to ensure future assessments are comprehensive as required by the Settlement Agreement. The Facility had developed an OT/PT audit tool that was in revision as the time of the review. Consequently, there was no data available, because the tool had not been implemented. The audit tool should be reviewed to ensure the essential components of assessments discussed in this section are present in the audit tool.	
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	**Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** The primary OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. PNMP content and format are discussed with regard to Section O.3, and staff compliance with PNMPs is reviewed with regard to Section O.5. All of the eight individuals in the sample had a PNMP. Six of the individuals had dining plans (i.e., Individual #210, Individual #192, Individual #161, Individual #34, Individual #156, and Individual #322). A review of the eight individuals' records found: ▪ For two of the eight ISPs reviewed (i.e., Individual #210 and Individual #34), (25%), a PT attended the annual meeting. A PTA attended for Individual #324. ▪ For five of the eight ISPs reviewed (i.e., Individual #43, Individual #210, Individual #192, Individual #322, and Individual #161) (63%), an OT attended the annual meeting. For individuals with OT/PT needs, the OT/PT should unless the team provides adequate justification. ▪ In none of the eight ISPs reviewed (0%), the PNMP was integrated in the ISP. ▪ In two of the ISPs reviewed (i.e., Individual #43 and Individual #192) (25%),	Noncompliance

#	Provision	Assessment of Status	Compliance
	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	skill acquisition programs were recommended. However, the six individuals' assessments indicated potential for skill development, but no skill acquisition programs were recommended. ▪ In none of the one ISP reviewed (0%) for Individual #210 who received direct OT intervention, skills learned in therapy were integrated into the individual's daily routine. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT unless the team provides justification; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. **Direct OT/PT Interventions** Two individuals on campus received direct OT and/or PT intervention. Individual #210 was to participate in OT treatments with activities designed to improve his abilities with leisure by riding his bike. Individual #250 was to receive PT treatments for two months (i.e., July and August 2012) by participating in activities designed to improve his head and trunk posture to improve respirations when sitting, standing, and ambulating. The direct OT intervention plan for one individual (i.e., Individual #210) was requested. His Consultation Report, dated 5/2/12, stated: "begin skilled OT therapy to address grasp, motor planning upper extremity strength, trunk control, coordination, and combining all components to safely operate his bike." However, no therapy intervention plan was submitted for review. Comprehensive progress notes related to OT and/or PT interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal; ▪ Description of the benefit of the goal to the individual; ▪ A report on the consistency of implementation; and ▪ Recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. For none of the one individual reviewed (0%) was documentation of OT intervention plan review comprehensive. The progress notes did not incorporate the essential components outlined above. **Indirect OT/PT Programs** At the time of the review, the primary indirect OT/PT support was the PNMP. For individuals who received indirect OT and/or PT programs (i.e., PNMPs), monthly	

#	Provision	Assessment of Status	Compliance
		documentation from the OT and PT should include: ▪ Information regarding whether the individual showed progress with the stated goal(s); ▪ A description of the benefit of device and/or goal(s); ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. For none of these eight individuals in the sample who received indirect OT and PT supports (0%) was documentation of the OT and PTs' review comprehensive. There were no progress notes. However, such notes should have incorporated the essential components outlined above. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect OT and PT supports.	
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.	**Competency-Based Training** The status of the Facility's compliance with competency-based training and monitoring for continued staff competency and compliance of direct support professionals was addressed with regard to Sections O.5, and O.6. **Individual-Specific Training** Eight of the eight individuals' staff had received training on individual-specific PNMP strategies. The status of individual-specific training was addressed in further detail with regard to Section O.5. No data had been compiled into a tracking system to allow analysis of PNMP individual-specific performance check-offs. Consequently, it was not possible to determine how many staff had successfully completed individual-specific performance check-offs (n) versus the total number of staff (N) needing to complete PNMP individual-specific training and performance check-offs.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the	**Monitoring System** The LBSSLC – IDT –Program Development OT/PT Services, Assessment, Update and Consultation Process policy, revised 2/16/10, stated: the HT Department will implement a system to monitor and address: ▪ The status of individuals with identified skilled occupational and physical therapy needs and PNMPs; ▪ The effectiveness of treatment interventions that address skilled occupational therapy, physical therapy plans, and physical and nutritional management	Noncompliance

#	Provision	Assessment of Status	Compliance
	condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	plans; and ▪ PNMP implementation, assessment, effectiveness, appropriateness, availability and condition of supportive equipment. However, as illustrated through the Monitoring Team's findings presented with regard to Sections O.6 and O.7 and within this section, the Facility's current monitoring systems did not adequately address these policy components. All of the eight individuals within this sample had PNMPs. Six of the individuals had dining plans (i.e., Individual #210, Individual #192, Individual #161, Individual #34, Individual #156, and Individual #322). A review was conducted of the individuals' Compliance Monitoring and OT/PT assessments resulting in the following findings: ▪ None of the eight individuals (0%) were monitored on an established schedule to assess the effectiveness of their physical and nutritional and therapy supports. ▪ Therapists for none of eight individuals' prescribed adaptive equipment (0%) assessed the equipment for condition, availability, and effectiveness. This finding was based on the fact that prescribed equipment was not addressed in OT/PT assessments for the condition, availability and effectiveness by therapists. ▪ None of the eight individuals (0%) were monitored for the status of their identified occupational and physical therapy needs. ▪ None of the eight individuals (0%) were monitored for the effectiveness of their direct and/or indirect therapy OT/PT programs. With regard to the use of the Compliance Monitoring Form: ▪ Three of the eight individuals' (i.e., Individual #34, Individual #161, and Individual #156) (38%) were monitored during one meal over the past six months utilizing the Compliance Monitoring Form. The following concerns were noted: o There was no established frequency for monitoring; o Individual #161 was at high risk for aspiration, choking and respiratory concerns. These risks should have required enhanced monitoring; and o Individual #156 experienced a choking incident on August 2, 2012, but was not monitored after this event. ▪ Two of the eight individuals' positioning (i.e., Individual #324 and Individual #43) (25%) was monitored two times over the past six months. The following concerns were noted: o Individual #43 was ranked at high risk for aspiration, fractures, falls, osteoporosis, respiratory, and skin integrity. This individual required	

#	Provision	Assessment of Status	Compliance
		enhanced monitoring related to the high health risk status. o Individual #324 was at high risk for aspiration, choking, constipation, falls, fractures, fluid imbalance, fractures, GI concerns, osteoporosis, respiratory, and skin integrity. This individual required enhanced monitoring related to the high health risk status. ▪ One of the eight individuals (i.e., Individual #192) (13%) was monitored three times over the past six months. She was at high risk for aspiration, choking, falls, fluid imbalance, fractures, GI concerns, osteoporosis, and respiratory. These high risks should have warranted enhanced monitoring. ▪ Two individuals (i.e., Individual #322 and Individual #210) (25%)were not monitored during the past six months, although they had PNMPs and identified PNM concerns. The Facility should develop and implement a monitoring system that encompasses the elements presented with regard to Section O.6.	

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

1. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals to determine appropriate OT and PT caseloads. (Section P.1)
2. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential components are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the OT/PT assessment audit form should include these components. (Section P.1)
3. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT unless the team provides justification; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.2)
4. The Facility should ensure comprehensive progress notes related to OT/PT direct interventions and indirect programs include:
    a. Information regarding whether the individual showed progress with the stated goal;
    b. A description of the benefit of the goal to the individual;
    c. A report on the consistency of implementation; and
    d. Recommendations/revisions to the direct intervention or OT/PT program as indicated related to the individual's progress or lack of progress. (Section P.2)
5. Individuals who receive OT/PT direct interventions and/or programs should be monitored for the following:
    a. The condition, availability, and effectiveness of their prescribed adaptive equipment;
    b. The status of their identified occupational and physical therapy needs; and
    c. The effectiveness of their OT and PT therapy programs. (Section P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months: ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ 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; ▪ Have refused dental services; ▪ 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; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documents confirmed pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; o Most recent comprehensive exams for one individual from each residence – copy from dental office's record of visit and copy form active record of same visit, including source of documentation for each record provided, for: Individual #154, Individual #217, Individual #160, Individual #281, Individual #65, Individual #322, Individual #284, Individual #161, Individual #140, Individual #282, Individual #182, Individual #132, Individual #272, and Individual #201; o Five most recent off site oral surgery 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/enhancement 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.), name, reason for appointment dates of refusals and date of completion; 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/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last onsite visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment – prophylaxis, annual, etc.); 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, home manager, team, etc.); o QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows last six months, including any ISPAs that documented discussion/action plans concerning dental refusals; 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 #53, Individual #61, Individual #113, Individual #132, and Individual #121; o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc., for: Individual #154, Individual #209, Individual #296, Individual #116, Individual #310, and Individual #51; o For the past six months, copies of any correspondence concerning restraint and sedation use at office visit (to QDDP, team, psychologist, etc.); o Copy of complete dental records for prior three years at SSLC, including progress notes (prophylactic, annual, emergency, restorative, etc./forms), completed, x-ray consult reports, restraint checklist, oral surgeon consults, etc., for one individual most recently seen from each residential unit, as well as table format with name, dates of annual exams, prophylactic exams, and dates of other treatment. Records for following individuals were submitted: Individual #209, Individual #120, and Individual #174; o In response to request for 10 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 (including pre-treatment sedation sheets), information was provided for five individuals:

	Individual #183, Individual #267, Individual #184, Individual #284, and Individual #51; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of 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 (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 five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #154, Individual #1, Individual #10, Individual #108, and Individual #280; o For those completing annual exams in past six months, oral hygiene rating in each exam listed per individual and date of exam; o List of those who receive suction tooth-brushing treatment; o List of those who have been identified as benefiting from suction tooth brushing treatment, but who are not receiving suction tooth brushing at time of Monitoring Team's visit (waiting for equipment, training, care plan revision, etc.); o Copy of 10 annual dental assessments completed in last 30 days and for the prior year for these same individuals: Individual #235, Individual #99, Individual #61, Individual #279, Individual #140, Individual #103, Individual #178, Individual #60, Individual #112, and Individual #288; o List of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams (including odontogram); o Copy of 10 most recent annual dental summaries provided for the ISP submitted for following individuals: Individual #76, Individual #235, Individual #10, Individual #73, Individual #171, Individual #22, Individual #114, Individual #4, Individual #19, and Individual #223; o The most recent/current Facility oral hygiene data (numbers and percentages of good, fair, poor ratings), with date of data; o For those individuals for which care plans/ISP indicate they brush their own teeth, the most recent two oral hygiene scores, with dates of the scores; o List of those individuals that floss their own teeth; o List of individuals provided instructions on flossing with dates of training; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list of reasons with documentation as indicated;

	○ Summary information on desensitization plans since Monitoring Team's last visit; ○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hour following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, date pneumonia documented, date of last dental visit, type of procedure/visit completed, and type of anesthesia (TIVA, oral, local, none, etc.) in past six months; ○ CPR certification list for Dental Department staff; ○ Sample of ISPAs addressing dental desensitization, and information providing evidence of implementation of dental desensitization plans; and ○ For Presentation Book for Section Q. ▪ **Interviews with**: ○ Russell Reddell, DDS, Dental Director.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Active Record review to determine if the following were completed: annual or initial examination form, oral cancer screenings, treatment plan, oral hygiene instructions, and whether or not cases in which TIVA was used had appropriate documents in place. ○ These monitoring/audit tools included indicators to allow the Facility to determine many aspects of compliance with the Settlement Agreement. However, the Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as record reviews. ○ The Self-Assessment identified the sample(s) sizes. However, this did not consistently include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). According to the Monitoring Tool information, each month the prior month review was to include a 100% sample of individuals provided dental services. The sample time period was the prior month (not quarterly, annually, etc.). However, this was not clear in the Facility's Self-Assessment document. For example, the Facility often indicated the review period and a number of records reviewed, but the Self-Assessment did not state if this represented all individuals for whom the indicator applied during the time period, or if a sampling methodology was used. However, based on the Monitoring Team's knowledge of the Facility's population, these sample size(s) were adequate to consider them representative samples. ○ The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tools: the Dental Director.

	○ The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. The QA Department had not begun to monitor using the new monitoring tools the Dental Department developed, and no inter-rater reliability review was submitted. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The following databases were used: annual dental exams, new admission exam, oral cancer screening, treatment plan, completion of radiographs, oral hygiene database, oral hygiene instructions, suction tooth brushing, dental emergency log, training rosters for oral care in-service training of DSPs, dental sedation/restraint database, database for no shows/refusals of appointments, dental positioning, annual summary completion, and TIVA database. The quality of the data maintained in the databases was noted to be complete and accurate**.** However, the database system was only functionally providing data in the 60 days prior to the Monitoring Team's onsite review. There was no information submitted to determine if the data had been reviewed or monitored to ensure data accuracy and completeness. ▪ The Facility presented data in a meaningful/useful way in a number of instances. However, concerns continued to be noted. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not show data related to the quality as well as presence of items. The clinical tools utilized measured the presence of annuals, treatment plans, etc., but did not measure the quality of these entries (e.g., completeness of tooth brushing instruction, quality of transition information, etc.). ○ Did not distinguish data collected by the QA Department versus the program/discipline. However, there was no data in the prior six months from the QA Department concerning dental services. ▪ The Facility rated itself as being in noncompliance with Section Q. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. However, the Monitoring Team's review indicated several other areas needing improvement (for example, based on the Monitoring Team's review, the rate of annuals completed was 60 to 70%, and 80% according to the Dental Department). The etiology of the different results was not identified. For areas in need of improvement, the Facility Self-Assessment referenced some actions that were being taken to address issued identified.
	Summary of Monitor's Assessment: The Dental Department had made some important strides. The new dental database was functional, and data could be obtained. The Facility's Self-Assessment contained results of data obtained through several databases from 2/1/12 to the present. The most recent annual dental examinations appeared to have updated odontograms. To minimize handwriting of the various dental progress notes, the Dental Department created a number of templates, specific to the reason for the dental visit.

	Areas remaining a challenge included the timely completion of annual exams, which was noted to be at 60%. There was need to develop a departmental policy concerning the type of documents that should be available in the dental record for cases in which TIVA was used (such as preoperative anesthesia clearance, preoperative medical clearance if indicated, guardian consent, current HRC approval, etc.). Desensitization plans appeared to be completed, but there was no information provided to demonstrate progress in implementing any plan. There continued to be a need for more information concerning the reason for missed appointments in order to begin to increase the rate of completed appointments. Dental summaries needed concise statements of the level of risk, tooth brushing instructions, and requirements and considerations for community preparedness, all areas important to the IDT ISP discussions. One challenge ahead will be taking the database information and using it to improve the quality of services. There were many areas that remained outstanding, and demonstration of progress in each of the above areas as well as others described in the narrative report will require innovation in the Dental Department, and some areas will require cooperation from other departments.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	A Dental Director, a staff dentist, one dental hygienist, and two dental assistants staffed the Dental Department. An individual training record from 1/1/2011 through 10/3/12 showed that all Dental Department staff were current in CPR certification. <u>Annual Assessments</u> Copies of the annual dental examinations completed in the six months prior to the Monitoring Team's visit were submitted. For each individual, a copy of the prior annual dental examination also was submitted. A total of 84 annual assessments were recorded as being completed during that time. Of these, two individuals were new admissions. As a result, there were 82 with a prior annual dental assessment. Of these, 57 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 70%. Additionally, for eight of the 57, 2012 annuals were documented as attempts, and the dentist was unable to complete the examination due to the individual's inability to cooperate. For completed annual dental examinations documented within 365 days of a prior exam, the compliance was 49 of 82 (60%). Separately, a list (undated) of those for whom an annual exam was due from 2/1/12 through 8/14/12, was submitted, including an indication of whether the exam was completed. This listed 116 names, and the document indicated that 94 were completed. However, the dates of completion were in 2011 for 11 of these names. According to these dates, 94 less 11 resulted in 83 completed annual exams for a compliance rate of 83 out of 116 (72%). If each of these 11 names had dates of completion that were a typographical error, the compliance rate was 94 out of 116 (81%). Also of note, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		number of exams and results did not agree with the information discussed in the paragraph above. That information included copies of both current and prior exams to verify the dates of completion. The Dental Department documented that there were no individuals residing at LBSSLC who had not seen a dentist during the year prior to the Monitoring Team's visit. Separately, copies of the 10 annual dental assessment that were completed in the 30 days prior to the Monitoring Team visit along with the prior year's completed assessment were submitted. For four out of 10 (40%) of these individuals, an annual dental assessment had been completed within 365 days. A new template had been created which was used in the 10 annual dental assessments. This minimized the need for handwriting. The content included the following: ▪ Intraoral exam was recorded in 10 of 10 (100%) of examinations. ▪ Oral cancer screening was recorded in 10 of 10 (100%) of examinations ▪ None of the 10 individuals were edentulous. ▪ An oral hygiene plan was included in none of 10 (0%) examinations. ▪ An oral hygiene rating was included in 10 of 10 (100%) examinations. ▪ Tooth-brushing instruction was recorded in none of 10 (0%) examinations. ▪ Behavior was described in none of 10 (0%) examinations. ▪ A treatment plan for the next visit was recorded in 10 of 10 (100%) examinations. ▪ Positioning needs were recorded in none of 10 (0%) examinations. ▪ Desensitization was discussed in none of 10 (0%) visits. ▪ Transition planning needs were reviewed in none of 10 (0%) visits. Copies of the completed annual assessments for 14 individuals were submitted. Each included the annual assessment from the IPN entry, and the dental progress note (DPN) entry from the dental office record. The following findings were made with regard to the IPN and DPN notes related to the annual assessments: ▪ 14 of the 14 submitted individual annual assessments had an entry in both the dental office record and active record (100%). ▪ Five of the 14 (36%) had identical information recorded in the DPN and IPN. ▪ A template form was completed in eight DPNs and one IPN. A briefer template was completed in three DPNs and six IPNs. Handwritten notes occurred in three DPNs and eight IPNs. Handwritten entries appeared to be more comprehensive in DPNs and brief in IPNs. For one individual, a DPN was not submitted. One DPN and one IPN had both a stamp template and a handwritten entry. Additionally, during the time period from March 1, 2012 (cut off date not indicated), there were three new admissions. Three out of three had completed an initial dental	

#	Provision	Assessment of Status	Compliance
		exam in the first month (from 15 to 22 days). The Facility submitted the complete dental records for the prior three years for one individual from each residential unit, as a separate measure of completeness and timeliness in dental documentation. Three records were submitted, and the following findings were based on the review of this material: ▪ For three out of three (100%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ None of three individuals were edentulous. ▪ For one of three, there was an emergency visit within the prior three years. ▪ For those with teeth, a periodontal chart was completed/documented in none of three (0%) records. ▪ A permanent dentition chart/odontogram was completed for one of three (33%) individuals. ▪ The dental treatment plan (past year 2011 to 2012) was documented in none of three (0%) records. ▪ The dental treatment plan record was current in one of three, current and incomplete in one of three, and not updated in one of three. ▪ None of three (0%) had a separate TIVA anesthesia pre-operative anesthesia record. ▪ Three of three (100%) had submitted a TIVA anesthesia record for 2012. ▪ For two of three (67%), up-to-date HRC approval for TIVA anesthesia was submitted. ▪ For three of three (100%), current family/guardian consent was submitted. ▪ None of three (0%) submitted an annual dental summary for 2012. ▪ None of three (0%) submitted an annual dental summary for 2011. ▪ Three of three (100%) had information submitted concerning the completion of dental x-rays in 2012. ▪ The level of cooperation and need for sedation/restraint was documented in three of three (100%). ▪ The oral hygiene index rating was recorded in three of three (100%) records. ▪ In the 2011 and 2012 dental record annual examination documentation (forms LuSSLCD-1 and LuSSLCD-3 dental progress note form), the determination of dental risk used for the IRRF and IDT discussion was recorded in none of three records (0%). ▪ In the 2011 and 2012 dental record annual examination documentation (forms LuSSLCD01 and LuSSLCD-3 dental progress note form), toothbrush instruction was recorded in none of three records (0%). ▪ In the 2011 and 2012 dental record annual examination documentation (forms LuSSLCD-1 and LuSSLCD-3 dental progress note form), the recommendations for oral hygiene (tooth-brushing recommendations/flossing, etc.) was recorded in	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
none out of three records (0%).
▪ In 2011 and 2012 documentation, a statement of preparedness for community transition was recorded in none out of three records (0%).

<u>Oral Hygiene</u>
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 the entire year. According to this document, for a census of 214 individuals, 22 (10.28%) had a good oral hygiene score, three had a fair to good rating (1.4%), 110 (51.4%) had a fair oral hygiene score, one had a poor to fair rating (0.47%), 24 (11.21%) had a poor rating, and 54 (25.23%) had no rating on file. None of the edentulous individuals had ratings.

<table>
<tr><th colspan="3">Oral Hygiene Ratings for Previous Six Months from Annual Exams- %</th></tr>
<tr><th>Rating</th><th>2/1/12 to 8/21/12</th><th>9/1/11 to 2/1/12</th></tr>
<tr><td>Good</td><td>Four (5%)</td><td>34%</td></tr>
<tr><td>Fair/Fair to Good</td><td>66 (85%)</td><td>51%</td></tr>
<tr><td>Poor/Poor to Fair</td><td>Eight (10%)</td><td>15%</td></tr>
</table>

Compared to the entire year data, the most recent six month information obtained at the most recent annual exam, indicated fewer individuals with a rating of good oral hygiene (from 10.28% for the entire year to 5% for the more recent six months), more had a fair oral hygiene score (from 51.4% for the entire year to 85% for the more recent six months), and fewer had a poor rating (from 25% for the entire year to 10% for the last six months). This suggested some of those with good oral hygiene declined in dental hygiene and some with poor dental hygiene improved.

It was noted that the Dental Department provided different results of oral hygiene ratings than the information for 2/1/12 to 8/20/12, but the trend identified was the same. Several factors were identified by the Dental Department that might have led to the decreasing trend in good ratings, a decrease in poor ratings, and an increase in fair ratings. These included the addition of a new dentist that might not have understood the oral hygiene index use at LBSSLC, the decrease in the use of suction tooth brushing, and the improved accuracy and completeness of the dental database.

Suction Tooth Brushing
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 61
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		individuals received suction tooth brushing, which was 61 out of 211 (29%) of the population. A separate list was submitted for those who had been identified as benefiting from suction tooth brushing treatment, but who were not receiving suction tooth brushing. This list totaled 33 individuals, or an additional 16% of the population. *Tooth Brushing* The Dental Department began to implement in-service training by the dental hygienist in the homes. The focus of training was appropriate personal protective equipment to be worn when assisting in oral care of the individual by direct support professionals and nursing staff. According to the infection control committee meeting of May 2, 2012, the RN Case Managers were in–serviced by the dental hygienist. Following this, the RN Case Managers were to provide in-service training to staff in the homes. Subsequent meetings did not provide any numbers of training sessions by the RN Case Managers, or numbers of staff trained. It could not be determined from the information provided in subsequent infection control committee meeting minutes the degree of success of this training program. The dental hygienist was scheduled to begin each workday in a randomly assigned home. Time in the home was to be from 6:30 a.m. to 8:00 a.m. unless there was a general anesthesia clinic. Duties were not listed, but hopefully included monitoring and teaching tooth brushing to individuals, and instructing direct support professionals in assisting tooth brushing of the individuals. Three individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of these three individuals were submitted for the prior two ratings. For two individuals the prior two ratings were both scored as fair. For one individual, the score in 4/4/11 was fair and the score in 6/13/12 was poor. The scores were nine to 14 months apart. No individual flossed his or her own teeth. Based on documentation provided, none had been instructed to floss their teeth "due to their lack of dexterity." This overgeneralization was concerning, because individuals should be assessed to determine their specific skills and abilities to complete the flossing task. *X-rays* The Facility submitted a list of those who had outstanding need for dental x-rays. These were not categorized by priority. According to the Dental Department, 11 individuals were overdue for recommended dental x-rays. All needed "full mouth radiographs in a hospital setting." The date of last radiographs for these 11 individuals was not stated. There was no information provided that demonstrated attempts at completing these x-rays in the hospital setting, or whether there was a contraindication, lack of consent, etc.	

#	Provision	Assessment of Status	Compliance
		Edentulous Individuals Information submitted indicated 18 individuals residing at LBSSLC were edentulous, for a rate of 18 out of 211 (8.5%). None became edentulous in 2012. Two became edentulous in 2011, and one was admitted edentulous in 2011. Three became edentulous in 2010. Two became edentulous in 2009. Eleven became edentulous prior to 2009. A separate list indicated there were 19 individuals that were edentulous, and of these 19, two individuals had dentures. For one individual, the denture was issued prior to admission to LBSSLC. For one individual, the denture was issued at LBSSLC. For this latter individual, several sets of dentures had been made, but the individual had a history of destroying them when agitated. Seventeen individuals that were edentulous did not have dentures. Most of the 17 individuals had more than one reason for not having dentures. Reasons given were: lack of adequate bone structure (14 individuals), tongue thrust (five individuals), dysphagia (10 individuals), individual's lack of interest in a denture (17), and a habit of placing entire hand inside the mouth (one). <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department provided the breadth of services required to care for the individuals at LBSSLC. From 2/1/12 through 8/31/12, 62 individuals were seen for 65 prophylactic care appointments. Thirteen individuals underwent restorative care during 17 appointments from 2/1/12 through 8/31/12. There was one additional individual listed for restorative care, which was rescheduled, and no information was available to determine current status (completed/open). Fifteen individuals were seen and treated for dental emergencies. Seven individuals underwent dental extractions (from one to seven teeth were extracted) from 2/1/12 through 8/21/12. *Oral Sedation* Monitoring and evaluation of use of oral sedation was reviewed. Four active records were submitted for individuals who underwent oral sedation. Ten records were requested, and five provided, but one individual had general anesthesia and not oral sedation. The following summarizes the results of this review for the four individuals that used oral sedation. One individual had two appointments with oral sedation. Five appointments were reviewed: ▪ Two out of the five appointments (40%) confirmed nothing by mouth status or nothing per G-tube. None of the individuals were documented to not need NPO status. ▪ Five of five (100%) listed the medication administered and the dose. Four of five (80%) listed the route. ▪ Four of five (80%) documented vital signs obtained in the home prior to the visit. ▪ One of five (20%) listed pre-procedure vital signs in the dental office.	

#	Provision	Assessment of Status	Compliance
		▪ Four of five (80%) had an examination note on the date of the visit. ▪ One of four (25%) documented intra-procedure vital signs. For one individual, the visit was too brief to obtain vital signs. ▪ Three of five (60%) documented post- procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in four of the five (80%) of the active records. ▪ For none of five (0%) was there documentation submitted by the Dental Department concerning follow-up the next business day. ▪ None of five (0%) documented a post-dental procedure IPN note. ▪ Five of five (100%) included documentation of current sedation consent. Although in one case, only the first page of the consent was copied for review. ▪ Four of five (80%) included documentation of current HRC approval. ▪ One of five (20%) cases included a restraint checklist and four of five (80%) used a pre-sedation assessment form. *General Anesthesia/TIVA* An undated list documented 61 appointments for 49 individuals utilizing TIVA. Date range of the appointments was 2/10/12 through 8/22/12. Of these, 10 appointments were refused, for a show rate of 51 out of 61 (84%). Five individuals required rescheduling multiple times, but five of these five had a documented completed appointment utilizing TIVA. Two individuals refused three times before a fourth visit was successful. The Facility submitted information that there had been no injury following TIVA administration since the Monitoring Team's last visit. The active record was requested for six individuals who had undergone general anesthesia in 2012. One submitted case did not have general anesthesia or did not include documents if general anesthesia was given. For the remaining five individuals, the date range of these procedures was from 5/11/12 through 8/22/12. The procedures under general anesthesia included one or more aspects of dental care. The list varied in each case, and included the following: annual exam, prophylaxis, x-rays, and extractions. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was submitted and current (defined as completed and dated within 365 days of the procedure) in four of five cases (80%). ▪ HRC approval was submitted in four of five cases (80%) ▪ A pre-operative medical clearance was completed and submitted in none of five cases (0%). ▪ A pre-operative anesthesia record/clearance was completed and submitted in none of five cases (0%). ▪ The operative anesthesia record was submitted in four of five cases (80%). ▪ For those with teeth, a periodontal chart was submitted for none of five (0%).	

#	Provision	Assessment of Status	Compliance
		▪ Pre-operative vital signs were recorded in four of five cases (80%). ▪ Intra-operative vital signs were recorded in four of five cases (80%). ▪ Postoperative vital signs were recorded in four of five cases (80%). ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score or "Discharge Scoring System" was submitted in four of five (80%) of the active records. ▪ A recovery note was submitted for none of five (0%). ▪ Pain medication was prescribed in none of one case in which extractions occurred. *Extractions* For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, consent was submitted in none of five (0%). ▪ A prior dental IPN/DPN indicating the need for extractions was documented in three of five (60%). ▪ Date and time of the appointment for the extraction procedure was recorded in five of five cases (100%). ▪ For five of five cases, IV sedation/general anesthesia was used. For none of the five cases, oral sedation was used. None utilized a local anesthetic only. For five of five, a combination of IV sedation/general anesthesia and local anesthetic were used. ▪ From one to 10 teeth were extracted at a visit. ▪ Vital signs (pre, intra, or post procedure) were documented in the DPN in none of five (0%) cases. ▪ Pain medication was documented as being prescribed in two of five (40%) cases. ▪ A follow-up phone call to the home was documented in none of five (0%) cases. ▪ A follow-up visit was documented in none of five (0%) cases. It was noted that LBSSLC did not refer individuals to community oral surgeons. The part-time dentist was an oral surgeon, and oral surgery procedures could be completed on campus. The Facility was requested to submit a list of individuals with documented pneumonia in the prior six months, along with the date of the last dental visit, type of visit, and type of anesthesia provided at that visit. A total of 16 names was submitted. Of these, 14 had annual exams, and two had prophylaxis treatment. One had an "exam" and dental x-rays. One had general anesthesia. The other 15 had no anesthesia. The date of the dental visit prior to the pneumonia was provided for 12 of the individuals. For four individuals, the dental visit date provided occurred after the pneumonia. For the 12 individuals for whom a dental visit date was provided prior to the onset of pneumonia, there were two	

#	Provision	Assessment of Status	Compliance
		individuals for whom pneumonia occurred two to six days after the dental visit. These two individuals were considered to have fair oral hygiene. For the 16 cases of pneumonia, one individual had a good oral hygiene rating, 13 had a fair oral hygiene rating, and two had a poor oral hygiene rating. For those individuals who had pneumonia, or a history or recurrent pneumonia, more frequent dental exams for prophylactic treatment should be considered, along with close monitoring of adequacy of tooth brushing in the home. *Emergency Treatment* The Dental Department provided a "Dental Emergency Log" for the months of February through August 2012. These logs reflected 17 appointments for 15 emergencies. Of these 15 completed dental emergency appointments, 14 were seen the same day as the emergency contact with the Dental Department. There were two calls for emergency appointments that were scheduled the same day, but the individuals refused the appointments. The Dental Department was subsequently called a second time, and the appointment was kept the same day. For one individual, there was a tooth found on x-ray in the gastrointestinal tract, and the individual was seen in the dental clinic. Although this was included in the emergency dental log, it did not appear to be an emergency, although a follow-up evaluation was indicated. The "Dental Emergency Log" tracked these emergencies to completion. Of the 15, 14 were tracked to closure. The one with no information concerning closure occurred in August 2012, and there might not have been sufficient time for closure to the case. Ten of the 15 individuals with emergency cases had pain on presentation. The number of emergency appointments per month was as follows: February 2012 – none, March 2012 – seven, April 2012 – two, May 2012 – two, June 2012 – four, July 2012 – none, and August 2012 – two. Treatments included tooth brushing, examination, cleaning, oral rinse, restorative care, and x-ray. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: toothache, and/or pain in gum. For one individual, the reason was not recorded. The following findings are made based on this review: ▪ Four of five records (80%) documented the presence or not of pain. ▪ Pain was documented in four cases. Pain was treated in two of four cases by the Dental Department, in one of four cases by the PCP, and by other non-pain medication for one of four cases. ▪ Follow-up was submitted for one of five individuals (20%).	
Q2	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	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. <u>Policies and Procedures</u> According to the Dental Department, there were no additional intra-departmental policies or procedures created in the previous six months. However, according to minutes from the SSLC State Dental Conference of June 28 to 29, 2012, a statewide restraint policy became effective 6/1/12. Specific to the Dental Department, oral sedation required a restraint checklist, but TIVA did not. Minutes from the 9/11/12 dental conference call documented that there was a new statewide consent process in which three physicians/dentists needed to sign for consent (one was listed as another physician primarily in private practice). Following this consent process, the form was to be forwarded to the HRC for review and approval. At the current time, all extractions and sedation needed HRC approval. This might be expanded to include restorative dentistry. With additional steps in the consent process, it is recommended that the Dental Department create a tracking system to determine which steps/signatures in the new consent process have been completed and which remained outstanding. It would also be helpful to track the time involved to determine the impact of the new more complex process, and to ensure additional steps are taken to fast-track the consent process to minimize delay in treatment of the individual. <u>Provision of Dental Records to IDTs</u> Copies of the 10 most recent annual dental summaries were submitted, as of 9/4/12. The IDT members used these to interpret dental needs of the individual during the ISP. A color print copy of each was submitted. The template provided succinct information that was entered by computer, so handwritten entries did not occur. Contents of the template included the number of refusals and broken appointments, the behavior with attempts without medication, the date of the last annual exam, the date of the last prophylaxis, the oral hygiene rating, tissue health, any type of sedation required, need for restraint, whether the individual had a desensitization plan, community placement evaluation, level of periodontal disease and level of risk for caries, the degree of periodontal disease present, whether caries were present, and whether there was bruxism. A color-coded odontogram (tooth chart) was completed. Treatments completed and treatments recommended were documented, and there was a final descriptive component commenting on unique challenges in dental care of the individual. A few observations are noted. It was assumed, but not identified that the refusals and broken appointments were over the past one year of the completion of the annual dental	

#	Provision	Assessment of Status	Compliance
		summary. However, this was not clearly stated. Similarly, the treatment completed likely summarized the past one year of procedures or treatment from the last annual dental summary, but this was not clearly stated. The IDT members would benefit from information about the tooth-brush instructions/oral hygiene instructions that the residential staff are expected to complete on a daily basis in ensuring dental care of the individual in the home, as well as positioning, steps leading to cooperation, flavor of toothpaste the individual prefers and that allows for increased cooperation, type of toothbrush, aspects of tooth brushing that the individual completes successfully, etc. The Dental Department created a number of templates to be used in the dental progress note section of the dental record. This was to minimize handwriting, and reduce illegibility. A number of templates were submitted specific to the reason for the visit, identified by the "S" of the SOAP format: ▪ S. Patient presents for prophylaxis; ▪ S. Patient presents for exam; ▪ S. Patient presents for extractions; and ▪ S. Patient presents for fillings. <u>Refusals/Missed Appointments</u> A review of recent information from LBSSLC for dental appointments was submitted entitled: "LBSSLC Individuals Refusing Dental Services, Reporting Dates 2/1/2012-8/21/12." This indicated 42 appointments were refused. A separate report with dates 2/1/12 through 9/5/12 indicated that 41 individuals refused appointments. This database indicated that there were 272 appointments scheduled from 2/1/2012 through 8/31/2012. There were 41 refusals listed, and 48 non-refusals/no shows/cancellations for other reasons. Combined this was a show rate of 67%. Reasons for the scheduled appointments that were refused included: cleaning (two appointments), extractions (one appointment), annual exam (26 appointments), restoration (one appointment), procedures involving TIVA (two annual, three recall/prophylactic, two recall/x-rays, one x-rays/exam, one not specified), emergencies (two appointments), and examination not further described (two appointments). The number of refusals per month follow: February 2012 – six, March 2012 – eight, April 2012 – seven, May 2012 – six, June 2012 – three, July 2012 – seven, August 2012 – five. One document was submitted ("Individuals refusing dental services," for 2/1/12 to 9/5/12) indicating whether individuals that had missed an appointment for reason of refusal had a completed follow-up visit. For 41 refused appointments, there was a successful follow up in 17 (41%). Two documents were submitted indicating whether individuals that had missed an	

#	Provision	Assessment of Status	Compliance
		appointment for all reasons (refusals, non-refusals), had a completed follow-up exam. Of the 89 missed appointments, 37 of the 89 had a completed follow-up visit documented as of the date of the document submitted ("All missed and refused dental appointments," dated 9/5/12). For 52 individuals, there was no documented follow up of a missed appointment. This was a follow-up completion rate of 37 out of 89 (42%). It was noted that for several individuals, no information was recorded regarding whether there was a follow-up completed. From a second document entitled "Dental Appointments Attendance Sheet," information appeared to be more complete than in the first document. This listed a follow up for 60 of the 89 missed appointments. This was a follow up completion rate of 67%. It is recommended that, as the databases are developed, accuracy and completeness be monitored at routine intervals. For the time period from 2/1/2 through 9/5/12, there were 48 non-refusals/missed/no show/cancellations of appointments. Reasons for the scheduled appointments that were missed included cleaning (seven appointments), annual exams (32 appointments), annual with cleaning (one appointment), emergency (one appointment), extractions (no appointments), dentures (one appointment), and restorations (five appointments). No information was provided for one missed appointment. The major reasons identified for missed appointments included: dental clinic (31), behavior (three), staffing (one), transportation (one), unknown (nine), and no information provided (three). Of the 48 non-refusals, 12 of 48 (25%) did not have an identified reason, indicating that the Dental Department needs increased collaboration and communication with the homes to determine the reason for non-refused missed appointments. Also, the dental clinic category was responsible for 31 out of 48 (65%) of the non-refusal missed appointments. It is recommended that this be further categorized to determine reasons and a corrective action plan developed to address preventable causes. Data was submitted for missed or refused dental appointments by the residence. Several residences had repeat refusals. In Home 516, 12 individuals missed or refused 25 appointments. In Home 504E (a home supporting medically complex individuals), 13 individuals missed or refused 15 appointments. In Home 514, seven individuals missed 10 appointments. In Home 520W, six individuals missed nine appointments. This data provided an opportunity for increased collaboration between the Dental Department and the residential staff/psychology department to develop programs to increase compliance for those with sensory defensiveness, and behavioral issues, or for individuals with medical complexities that are ill during the time of the appointment to reschedule ahead of time so that there is not a "last minute" cancellation. For the months of June 2012 through September 2012, on a monthly basis, the Dental Department completed a "Missed Appointment Analysis" per home. Individuals with	

#	Provision	Assessment of Status	Compliance
		missed appointments were identified and appeared to be tracked to completion. It appeared these were completed per month on a quarterly basis, and were utilized in the following quarterly dental review of missed appointments. The Dental Department submitted a "Missed Appointment Analysis, Last Quarter FY 2012." Five individuals in four homes were identified. The conclusion was that dental desensitization plans would need to be created. The follow-up step to this conclusion was not provided. A work group with representation from Dental, Medical, Nursing, and Residential Departments met (undated) to resolve the problem of missed dental appointments. A summary of the suggestions from this meeting was submitted. The Dental Department had stopped sending daily emails about missed appointments due to no response. However, it was determined at this work group meeting that the emails were sent to the wrong staff. This was corrected, and the email notification of missed appointments resumed. This change was noted to reduce the no show rate to 5%, although a review of the data verifying improvement and impact was not submitted. The Dental Department submitted a statement that it was "not aware of any minutes from IDT meetings that review, assess, develop strategies for Dental Visit missed appointments." As the renewed notification to the homes about the missed appointment continues, it would be anticipated that the IDTs would meet to determine resolution steps for refusals/no shows. The discussion and decisions should be documented in an ISPA, and the Dental Department should be present at those meetings and obtain a copy of the ISPA. The Dental Department should consider periodic dental staff meetings to review the progress or lack of progress in resolving no show appointments, and develop additional options which can be presented at a requested follow-up meeting should this be a continuing challenge. <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 February 1, 2012 through August 31, 2012, according to the data provided, 183 appointments were completed. Of these, there were seven appointments in which oral sedation was given (3.8%), and 51 (27.8%) for which IV sedation was administered. Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation, dated 8/21/12. A total of 128 individuals were listed with HRC approval for dental sedation, along with expiration dates. Expiration dates ranged from 3/10/11 through 4/18/13. Of these 128 individuals that required dental sedation,	

#	Provision	Assessment of Status	Compliance
		73 had obtained approval for TIVA, 32 had obtained approval for oral sedation, and four had obtained approval for both oral sedation and TIVA. For 19, information was not included in the table of information submitted. A total of 18 of the HRC approvals were current. With regard to the Facility's efforts to develop and implement desensitization plans or other strategies to reduce the need for restraint: ▪ As of 8/6/2012, 101 individuals had been identified as requiring desensitization or other plan to reduce the need for restraint. Updated information from 9/25/12 documented that 117 individuals had been identified as requiring a desensitization plan or other plan to reduce the need for restraint. ▪ Of these, for August 2012, 77 had skill acquisition plans developed. In comparison, for June 2012, 54 individuals had skill acquisition plans that were considered current. For July 2012, 74 individuals had skill acquisition plans that were considered current. Updated information from 9/25/12 indicated that 97 individuals had skill acquisition plans developed. ▪ 107 individuals had pre-sedation rights restrictions for dental services as of 8/6/12. For 22 individuals, rights assessments were outdated or not available. Updated information from 9/25/12 documented that 119 individuals had pre-sedation rights restrictions for dental services. ▪ Of the 77 individuals with skill acquisition plans developed as of 8/6/12, information (i.e., copies of daily tracking log from the home, copies of tracking log during dental office encounter, monthly log review/reports to determine whether implementation was occurring and a review of results, etc.) was submitted indicating implementation for none of 77 (0%). ▪ Evidence of progress in ability to cooperate for dental procedures through desensitization was submitted in none of 77 (0%). ▪ Evidence of lack of progress in desensitization was submitted in none of 77 (0%). ▪ Evidence of monitoring (monthly analysis) for progress in desensitization was submitted in none of 77 (0%). ▪ Of the 77 individuals with skill acquisition plans developed, information documenting changes/revisions in the skill acquisition plans to adapt to the needs of the individual was submitted in none of 77 (0%). <u>Quality Assurance/Improvement Initiatives</u> The QA Department was to use the following monitoring tools to review the quality and completeness of dental care: ▪ Submitted was a document entitled "Dental Database for Monitoring: Guidelines." Listed were 22 measurement tools of quality of dental services.	

#	Provision	Assessment of Status	Compliance
		The source database was also listed. The guidance indicated a monthly meeting of the Dental Director and QA representative was to be held to review data from the current month, as well as data for the prior quarter. Data for the 22 measurement tools was to be recorded in a template. It was not stated if the data collection was to occur through the Dental Department staff or through QA staff. ▪ Measurement indicators included the following: o Percentage annual dental examination completion within 365 days of prior annual; o Percentage new patient examinations completed within 30 days of admission; o Percentage initial and annual examinations included an oral cancer screening; o Percentage of Annual or Initial Examination form completed at time of exam; o Percentage of initial or annual examinations with a documented treatment plan; o Oral hygiene rates for the most recent specified time period; o Percentage of individuals provided oral hygiene instruction as appropriate; o Percentage of individuals that received recommended preventive care; o Percentage of dental emergencies evaluated within one business day; o Percentage of emergency follow-up completed as ordered by the dentist; o Percentage of extractions completed based on appropriate justification; o Percentage of individuals with dental extractions that had a follow-up appointment or other closure; o Percentage of individuals receiving pre-treatment sedation that had record documentation of effectiveness of pre-treatment sedation; o Percentage of dental sedation/restraint checklists completed and included pre-procedure, intra-procedure, and post-procedure vital signs; o Percentage of TIVA cases with a completed anesthesia record that included a discharge scoring system score; o A determination of whether QA analysis of data verified accuracy of database; o Percentage of dental appointments with no shows reported in most recent specified time period; o Percentage of dental appointments with refusals reported in most recent specified time period;	

#	Provision	Assessment of Status	Compliance
		o Percentage of dental appointments with cancellations reported in most recent specified time period; and o Percentage of individuals with pre-treatment sedation that had a Dental Sedation Plan. The QA Department submitted information that monitoring of the Dental Department had been suspended from March through July. The QA/QI Quarterly Summary of 3/21/12 documented the development of the new dental database. Monthly, a sample size of eight records was to be reviewed, one by the dentist for inter-rater reliability. This process continued through February 2012. The QA/QA Quarterly Summary of 3/21/12 did not include tabulated information in the report. Strengths listed were that 100% of dental assessments had accurate documentation of findings (February 2012 and prior). Areas needing improvement included documentation describing the treatment provided (0% compliance), oral hygiene instruction (0% compliance), and a tracking system. The QA/QI Quarterly Summary of 7/10/12 confirmed that there was no monitoring during this time.	

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

1. The Dental Department should continue to 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)
2. 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)
3. 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)
4. The Dental Department should develop a plan and coordinate with the part-time dentist to minimize the percentage of individuals without up-to-date x-rays. (Section Q.1)
5. 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)
6. With additional steps in the consent process, the Dental Department should create a tracking system to determine which steps/signatures in the new consent process have been completed and which remained outstanding. It also would be helpful to track the time involved to determine the impact of the new more complex process, and to ensure additional steps are taken to fast-track the consent process to minimize delay in treatment of the individual. (Section Q.2)
7. The comments section of the annual dental summary should include are 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)
8. The Dental Department should continue to review the database information and for completeness and accuracy at routine intervals. (Section Q.2)

9. 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)
10. The Dental Department should increase collaboration and communication with the homes in determining the reason for non-refused missed appointments. (Section Q.2)
11. The dental clinic category of non-refused missed appointment should be further categorized to determine reasons and a corrective action plan implemented to address preventable causes. (Section Q.2)
12. The Dental Department should consider periodic dental staff meetings to review the progress or lack of progress in resolving no show appointments, and develop additional options that can be presented at a requested follow-up meeting should this be a continuing challenge. (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 Self-Assessment, Action Plans, and Provision Action Information for Section R; o For the following 22 individuals who had communication deficits, alternative and augmentative communication (AAC) system(s), and/or received direct and/or indirect communication supports: Individual #313, Individual #264, Individual #312, Individual #183, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #179, Individual #279, Individual #283, Individual #265, Individual #124, Individual #167, Individual #165, Individual #320, Individual #25, Individual #255, Individual #315, Individual #274, and Individual #2, the following documents: Communication Comprehensive assessment, Update and Assessment of Current Status, ISP and ISPAs for past year, Positive Behavior Support Plan, skill acquisition programs related to communication and supporting documentation for implementation (indirect supports), direct SLP therapy intervention plans and supporting documentation such as IPNs, monthly reviews by SLP, AAC programs and supporting documentation for implementation of indirect supports, individual-specific communication monitoring for past six months, and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o Policy and procedures addressing the provision of speech and/or communication services and supports including changes since the Monitoring Team's last visit; o Continuing education and other training completed by SLPs since the Monitoring Team's last visit with certificates of completion; o List of current SLP and audiology staff along with corresponding caseloads, and CVs for newly hired SLPs; o List of individuals with AAC devices; o Communication Master Plan List; o AAC Screening forms; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SLP assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o Copies of blank communication competency-based performance check-off sheets for new employees; o Inter-rater reliability compliance scores and corresponding audits; o List of individuals receiving direct speech services and focus of intervention; o Individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication;

	○ Minutes for Communication committee meetings held since the Monitoring Team's last review; ○ Minutes for Speech Department meetings held since the Monitoring Team's last review; ○ List of all general common area communication devices; ○ OT/PT Assessments, ISPs, and PNMPs for four individuals most recently assessed by an SLP for whom AAC device was recommended; ○ Blank communication competency-based performance check-off for individual-specific communication programs; ○ External consultant reports since last review; ○ Completed audits of SLP documentation; ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review; and ○ American Speech Hearing Association (ASHA) certification for SLPs. ▪ **Interviews with:** ○ Linda Thomas, Director of Habilitation Therapy, OTR; ○ Stephanie Carrillo, MS, CCC/SLP; and ○ Diane Johnson, MS, CCC, SLP. ▪ **Observations of:** ○ Residences 513 and 527.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 9/17/12. In its Self-Assessment, for each subsection, 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. For Section R, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Compliance Monitoring Tool. The HT Department and/or QA/QI staff were not using the Monitoring Tool for Section R. Based on interview, the Director of HT was in the process of revising the Monitoring Tool for Section R. ○ This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Compliance Monitoring tool was designed to monitor staff compliance with communication programs. This tool was not adequate to adequate to provide sufficient data to address the provisions of all of the subsections of Section R. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The Compliance Monitoring tool did not have adequate methodologies to substantiate compliance for the subsections of Section R. ○ The Self-Assessment identified the sample(s) sizes. The focus of the sample was individuals with AAC devices, communication needs, as well as individuals at high risk for

	challenging behaviors. Random samples were derived from individuals identified with a priority status for communication services. The Facility will need to clearly identify the total population (N) used to define the sample selected (n). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility's revision of the monitoring tool for Section R should provide adequate written procedures for the implementation of the monitoring tool. o The following staff/positions were responsible for completing the audit tools: Program Compliance Monitor. The HT Department monitoring was deferred due to a shortage of therapists. When the revised monitoring tool is implemented, the therapists should monitor with the Program Compliance Monitor and inter-rater reliability should be established. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. The QA/QI Quarterly Summary August 2012 stated inter-rater agreement was found to be 100% for Compliance Monitoring Tool. However, there was no data presented to substantiate inter-rater reliability between therapists and the Program Compliance Monitor. ▪ Did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had audited continuing education spreadsheets, and reviewed Behavior Support Committee meeting minutes. However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators; o Did not consistently measure the quality as well as presence of items; and o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section R. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an 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.
	Summary of Monitor's Assessment: The Facility was allocated five SLP positions. At the time of the review, the Facility had three full-time SLPs. One of the three SLPs was on leave. There were two vacancies. Two graduate level Speech Language students provided 724 hours of service during a clinical rotation from June to mid-August 2012. Following this clinical rotation, these students requested to continue providing clinical services for the remainder of their school year. The provision of a clinical rotation was a positive development that allowed students the opportunity to work with individuals with intellectual disabilities, and in addition, learn about the possibilities for future employment.

	Individuals' Speech and Language assessments were significantly improved from the last review. However, the assessments still were missing some essential components. Observations by the Monitoring Team and two SLPs noted an improvement in the presence of the individuals' alternative or augmentative communication systems. In addition, some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC systems. Although the Facility's Communication Services policy included some important components, a number were missing. It did not include the following key elements: monitoring for the use of communication adaptive equipment in multiple environments (e.g., home, day program, and work); the process for identification, training, and validation for monitors; the process of achieving inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). Based on documentation provided, adequate monitoring was not occurring of individuals' AAC equipment or its use.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** Nine individuals with a SLP Comprehensive Assessment completed in the last 12 months including: Individual #313; Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #165, Individual #25, and Individual #315; ▪ **Sample R.2:** five individuals receiving direct speech services including: Individual #279, Individual #283, Individual #265 Individual #210, and Individual #25; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits including: Individual #264, Individual #183, Individual #179, Individual #167, Individual #320, Individual #255, Individual #274 and Individual #2; and ▪ **Sample R.4:** 13 individuals with AAC systems including: Individual #313, Individual #312, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #283, Individual #265, Individual #124, Individual #165, Individual #25, and Individual #315. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>system is discussed with regard to Section R.4.

<u>Staffing</u>
The Facility was allocated five SLP positions. At the time of the review, the Facility had three full-time SLPs. One of the three SLPs was on leave. There were two vacancies. Two graduate level Speech Language students provided 724 hours of service during a clinical rotation from June to mid-August 2012. Following this clinical rotation, these students requested to continue providing clinical services for the remainder of their school year. The provision of a clinical rotation was a positive development that allowed students the opportunity to work with individuals with intellectual disabilities, and in addition, learn about the possibilities for future employment.

Based on SLP caseload documentation the Facility provided, the following chart represents the caseloads of the Facility SLPs:

<table>
<tr><th>Speech Language Pathologists</th><th>Current Caseload</th></tr>
<tr><td>SLP #1</td><td>PNMT SLP, supported 18 individuals on the PNMT caseload and 68 individuals on 504W, 513, 514, 523, and 526</td></tr>
<tr><td>SLP #2</td><td>This SLP was currently on leave. She was reported to support 69 individuals on 504E, 516, 517, 518, and 521. According to the documentation submitted, her caseload had not been reassigned.</td></tr>
<tr><td>SLP #3</td><td>Supported 72 individuals on 515, 520, 525, 527, and 528</td></tr>
<tr><td>SLP #4</td><td>Vacant position</td></tr>
<tr><td>SLP #5</td><td>Vacant position</td></tr>
</table>

The Facility did not indicate what an appropriate caseload would be for SLPs at Lubbock. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs.

<u>Qualifications</u>
The Facility had documentation to show appropriate qualifications for licensed SLPs.
▪ Three of three full-time SLP staff (100%) were licensed to practice in the state of Texas.
▪ Three of three full-time SLP staff (100%) had evidence of American Speech and Hearing Association certification.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Continuing Education Documentation of continuing education courses completed by the SLPs during the past six months was submitted. Based on documentation submitted, no State-sponsored webinars were offered in the past six months. The continuing education attended by the clinicians included the following courses: ▪ On 3/7/12, SLP #1 and SLP #3 attended Most Integrated Settings Information; ▪ On 6/6/12 to 6/7/12, SLP #1, SLP #2 and SLP #3 attended an Autism Conference; ▪ On 7/26/12, SLP #1 and SLP #3 attended Pediatric Feeding: The Basis from Neonatal Intensive Care Unit to Outpatient; and ▪ On 8/1/12 to 8/2/12, SLP #1, SLP #2 and SLP #3 attended Evidence-Based Practices for AAC Evaluation. Based on a review of continuing education completed since the last review: ▪ Three of three full-time SLP staff (100%) had completed continuing education relevant to communication and transferrable to the population served. **Facility Policy** The LBSSLC – IDT- Program Development: Speech/Communication Assessment Process policy was revised on 2/16/10. The Facility policy did not provide clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: ▪ Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.); ▪ Outline of an assessment schedule; ▪ Frequency of assessments/updates; and ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission). The following components were not included in this policy: ▪ Timelines for completion of comprehensive assessments (within 30 days of identification via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT); ▪ A process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to intervention plans; and	

#	Provision	Assessment of Status	Compliance
		▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. The Facility should expand the SLP policy to incorporate these essential components.	
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.	**Assessment Plan** A Master Evaluation Schedule Update, not dated, identified 215 individuals, their home, last evaluation, next evaluation and ISP date. The priority criteria for the SL Assessment Plan was in the process of being reviewed and revised. **New Admissions** Three individuals (i.e., Individual #30, Individual #27, and Individual #40) had been admitted to LBSSLC since the last review. An examination of their admission and SLPs assessment dates showed: ▪ Three of three individuals (100%) received a communication screening or assessment within 30 days of admission or readmission. **Communication Assessment** A Speech Language comprehensive assessment should include the following essential components: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed at least 10 working days prior to the annual ISP; ▪ Diagnoses and relevance of impact on communication; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to communication; ▪ Medications and side effects relevant to communication; ▪ Documentation of how the individual's communication abilities impact their risk levels; ▪ Description of verbal and nonverbal skills with examples of how the individual utilizes these skills in a functional manner throughout the day; ▪ Evidence of observations by SLPs in the individual's natural environments (e.g., day program, home, work); ▪ Evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who do not communicate verbally; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new communication skills; ▪ Effectiveness of current supports, including monitoring findings; ▪ A description of the individual's AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from an AAC	Noncompliance

#	Provision	Assessment of Status	Compliance
		device/system; ▪ Comparative analysis of health and functional status from the previous year; ▪ Comparative analysis of current communication function with previous assessments; ▪ Identification of the need for direct or indirect speech language services, as appropriate; ▪ Specific and individualized strategies to ensure consistency of implementation among various staff; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs, as appropriate, including the use of AAC as indicated for individuals with identified communication deficits; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Nine individuals' Speech Language comprehensive assessments (i.e., Individual #313; Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #165, Individual #25, and Individual #315) in Sample R.1 were evaluated for the presence of these essential components: ▪ Nine of nine individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Five of six individuals' SL assessments (i.e., Individual #210, Individual #26, Individual #160, Individual #165, and Individual #53) (83%) were dated as completed at least 10 working days prior to the annual ISP. Three individuals (i.e., Individual #203, Individual #315, and Individual #313) had assessments completed in 2012, but their current ISPs were not submitted. Consequently, it could not be determined if the assessment was completed at least 10 working days prior to the ISP. Individual #25's assessment was completed one day prior to his annual meeting. ▪ Eight of nine individuals' SL assessments (i.e., Individual #313, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #165, and Individual #25) (89%) included diagnoses and relevance of impact on communication; ▪ Eight of nine individuals' SL assessments (i.e., Individual #313, Individual #26, Individual #160, Individual #203, Individual #53, Individual #165, Individual #25, and Individual #315) (89%) included individual preferences, strengths, and needs; ▪ None of nine individuals' SL assessments (0%) included medical history and	

#	Provision	Assessment of Status	Compliance
		relevance to communication; ▪ None of nine individuals' SL assessments (0%) listed medications and discussed side effects relevant to communication; ▪ Four of nine individuals' SL assessments (i.e., Individual #203, Individual #210, Individual #315, and Individual #313) (44%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Nine of nine individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Eight of nine individuals' SL assessments (i.e., Individual #313, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #25, and Individual #315) (89%) provided evidence of observations by the SLs in the individuals' natural environments (e.g., day program, home, work); ▪ Eight of nine individuals' SL assessments (i.e., Individual #313, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #25, and Individual #315) (89%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; ▪ Nine of nine individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities; ▪ Nine of nine individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; ▪ None of nine individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings; ▪ Nine of the nine individuals' SL assessments (100%) assessed AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from AAC; ▪ None of nine individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year; ▪ Seven of nine individuals' SL assessments (i.e., Individual #313, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, and Individual #315) (78%) gave a comparative analysis of current communication function with previous assessments; ▪ Nine of nine individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Nine of nine individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Nine of nine individuals' SL assessments (100%) had a reassessment schedule; ▪ None of the nine individuals' SL assessments (0%) supplied a monitoring schedule;	

#	Provision	Assessment of Status	Compliance
		▪ Nine of nine individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC devices/systems, as indicated for individuals with identified communication deficits; ▪ Nine of nine individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and ▪ Nine of the nine individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Individuals' SL assessments were significantly improved from the last review. However, the assessments were missing some essential components as noted above. Consequently, these assessments were not yet adequate. The SLPs should consider the essential components that were not present in these assessments above when completing assessments to ensure assessments are comprehensive as required by the Settlement Agreement. The Facility had developed an assessment audit tool, but the tool had not been implemented. The Facility should expand the assessment audit tool to incorporate the preceding essential components. **SLP and Psychology Collaboration** Based on review of eight individuals' records in Sample #R.3 with Positive Behavior Support Plans (PBSPs) (i.e., Individual #264, Individual #183, Individual #179, Individual #167, Individual #320, Individual #255, Individual #274, and Individual #2), the following was noted: ▪ Two of eight communication assessments and PBSPs reviewed (i.e., Individual #264 and Individual #167) (25%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Eight of eight communication assessments reviewed (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 3/22/12 to 8/17/12, participation by a SLP was noted in 22 of the 24 meetings (92%).	
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	**Integration of Communication in the ISP** Based on review of the ISPs for 13 individuals in Sample R.4 who had AAC devices (i.e. Individual #313, Individual #312, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #283, Individual #265, Individual #124, Individual #165, Individual #25, and Individual #315), the following was noted: ▪ In seven of 13 ISPs reviewed for individuals with communication needs (i.e., Individual #165, Individual #160, Individual # 53, Individual #210, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	#265, Individual #124, and Individual #25) (54%), an SLP attended the annual meeting. ▪ In 12 of 13 ISPs reviewed (i.e., Individual #313, Individual #312, Individual #26, Individual #160, Individual #203, Individual #210, Individual #53, Individual #283, Individual #265, Individual #124, Individual #25, and Individual #315) (92%), the type of AAC device/system and/or communication supports (might include, but not be limited to, the Communication Dictionary and strategies for staff use) was identified. ▪ Communication Dictionaries for five of the 13 individuals (i.e., Individual #26, Individual #53, Individual #203, Individual #124, and Individual #315) (38%) were reviewed at least annually by the IDT as evidenced in the ISP. ▪ Eight of 13 ISPs reviewed (i.e., Individual #313, Individual #26, Individual #210, Individual #283, Individual #124, Individual #312, Individual #25, and Individual #315) (62%) included a description of how the individual communicated, including the AAC system if they had one. ▪ Two of 13 ISPs reviewed (i.e., Individual #124 and Individual #25) (15%) included how communication interventions were to be integrated into the individuals' daily routines. ▪ Nine of 13 ISPs reviewed (i.e., Individual #313, Individual #26, Individual #203, Individual #210, Individual #265, Individual #283, Individual #124, Individual #25, and Individual #315) (69%) contained skill acquisition programs to promote functional communication in the use of their AAC systems. Progress had been made in the integration of communication for individuals with AAC devices in annual ISP meetings. However, additional work needed to be done. The individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary and description of necessary changes, as appropriate; a description of how the individual communicates including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. **<u>Individual-Specific AAC Systems</u>** The Monitoring Team and two SLPs conducted observations in residences (i.e., 513 and 527) for four individuals with AAC systems (i.e., Individual #283, Individual #265, Individual #53, and Individual #203). Findings included the following: ▪ AAC systems for four of the four individuals (100%) were present. The presence of AAC systems for individuals was an improvement from observations conducted during previous reviews. ▪ AAC systems for none of four individuals (0%) were noted to be in use.	

#	Provision	Assessment of Status	Compliance
		▪ For four of four individuals with AAC systems (100%), staff instructions/skill acquisition plans related to the AAC system were available. ▪ Four of four individuals AAC systems (100%) were portable and functional. **General-Use AAC Devices** The Facility provided a List of General Common Area Devices that identified the location, type of device, and intent of device. One of the SLPs acknowledged that additional work needed to be completed to enhance the functionality of general-use AAC devices in residences and other environments. The Monitoring Team agrees the Facility should re-assess the functionality of general-use AAC devices in residences and other environments. **Direct Communication Interventions** At the time of the review, eight individuals received direct speech interventions. Direct communication-related intervention plans and supporting documentation (i.e., progress notes) for four individuals in Sample R.2 who received direct speech services (i.e., Individual #279, Individual #283, Individual #265, and Individual #25) were reviewed. Comprehensive progress notes related to communication interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal. ▪ A description of the benefit of the device and/or goal to the individual. ▪ A report regarding the consistency of implementation. ▪ Recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. For none of four individuals (0%), documentation of the SLP's review of communication interventions was comprehensive. The progress notes reviewed for the past six months did not incorporate the essential components outlined above. **Indirect Communication Supports** Individuals with AAC devices in Sample R.4 did have indirect communication supports/programs designed to assist the individuals and/or staff in using the AAC device or to enhance their skills in utilizing the AAC system. For such indirect supports, the SLPs monthly documentation should: ▪ Provide information regarding whether the individual showed progress with the stated goal(s); ▪ Describe the benefit of device and/or program for the individual(s); ▪ Identify whether or not implementation is consistent; and ▪ Identify recommendations/revisions to the program as indicated in reference to the individual's progress or lack of progress.	

#	Provision	Assessment of Status	Compliance
		However, there were no monthly progress notes provided to report on the effectiveness review/monitoring of the individual's progress with indirect SL supports. **<u>Competency-Based Training and Performance Check-offs:</u>** The NEO AAC Competency Drill Check-Off communication performance check-off, dated 2012-2013, required new employees to: ▪ Review a PNMP to determine if an individual had a hearing/vision problem, how an individual typically communicates and was able to verbally relate this information; and if an individual had personalized communication equipment; ▪ Look at a Communication Dictionary and determine what specific communication signals an individual uses to communicate the need for medical attention and how the staff should respond to the individual's communication; ▪ Look at a Communication Dictionary and determine if an individual had a personal communication system; ▪ Look at a Communication Dictionary to determine what shared communication systems were appropriate for a specific individual to use; ▪ Demonstrate the use of a shared communication system; ▪ Demonstrate the signs for eat and drink; and ▪ Demonstrate the ability to provide a tactile cue for an individual who was deaf and blind The communication performance check off was adequate to assess new employees competencies for communication. Based on information the Facility provided, since the Monitoring Team's last review, 169 of 169 new employees (100%) successfully completed NEO communication training. **<u>Individual Specific Competency-Based Training</u>** On a positive note, the SLPs had provided individual-specific training for AAC devices for the individuals in Sample R.4. Seven of the thirteen individuals' staff (i.e., Individual #312, Individual #283, Individual #265, Individual #26, Individual #315, Individual #53, and Individual #203) (54%) had received individual-specific training on their AAC devices. However, a review of the training check-offs did not require staff to demonstrate engagement with the individual using the AAC device. The SLPs should review staff performance check-off to ensure a demonstration component is required to test staff competency for engagement with an individual using his/her AAC device. In addition, the Facility will need to present data to identify the number of staff identified per individual that require training (N) and the number of staff trained (n) to substantiate the provision of individual-specific training.	

#	Provision	Assessment of Status	Compliance
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Monitoring System** The Speech/Communication Assessment Process policy stated the HT Department was responsible for implementation of a monitoring system to address: ▪ The status of individuals with identified therapy needs; ▪ The condition, availability, and appropriateness of AAC equipment; and ▪ The effectiveness of treatment interventions. In addition, the policy stated the Facility was responsible for the implementation of a monitoring system to address: ▪ Implementation and effectiveness of home programs being provided by direct support professionals; ▪ Communication systems were in good condition, readily available, and in use; and ▪ Environmental and generic devices were in good condition, readily available and in use. However, the policy did not address the following key elements: ▪ Monitoring schedule to include frequency; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (i.e., home, day program, work); ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (i.e., individual and systemic). The Facility should expand the local policy to include these essential components. Compliance Monitoring forms for communication the last six months for 13 individuals in Sample R.4 were reviewed and the following was found: ▪ There was no established frequency for monitoring individual's communication devices; ▪ None of 13 individual's devices (0%) were monitored for the presence of their communication system; ▪ None of the 13 individual's devices (0%) were monitored for whether or not their communication system was in working order; and ▪ None of the 13 individual's devices (0%) were monitored for use in a variety of environments. The Facility Self-Assessment noted a monitoring system was developed and implemented on 7/13/12. This reportedly involved the home staff completing monitoring during the night shift (i.e., Daily Home Check Form) to determine if	Noncompliance

#	Provision	Assessment of Status	Compliance
		communication devices were present, clean, working, and if repairs were needed. However, no evidence was submitted to substantiate the implementation of this monitoring system for the individuals in Sample R.4. In addition, AAC Individual Equipment Monitoring Forms were not submitted for individuals in Sample R.4. The primary concern was that individuals' devices had not been monitored for the preceding essential components. This was problematic. In addition, the Facility did not provide monitoring reports analyzing and trending results from the Compliance Monitoring forms, Daily Home Check form, and AAC Individual Equipment Monitoring form for communication monitoring. These reports should address at a minimum the following indicators: ▪ Compliance with established monitoring frequency; ▪ Equipment presence; ▪ Equipment in working order; ▪ Equipment used in various environments; and ▪ In the case a problem was identified, there was evidence of resolution.	

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

1. The Facility should complete an analysis to determine an appropriate caseload for SLPs at LBSSLC, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. (Section R.1)
2. The Facility should expand the local Communication Services policy to incorporate the following essential components:
    a. Timelines for completion of comprehensive assessments (within 30 days of identification via screening);
    b. Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT);
    c. A process for effectiveness monitoring by the SLP;
    d. Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment;
    e. Methods of tracking progress and documentation standards related to intervention plans; and
    f. Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. (Section R.1)
3. The Facility should review the revised SL assessment template and content guidelines to ensure the essential components for SL comprehensive assessments are addressed. The SLPs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audit should include these elements. (Section R.2)
4. The Facility should ensure communication assessments and PBSPs address the connection between the PBSP and the recommendations contained in the communication assessment, as well as contain evidence of review of the PBSP by the SLP. (Section R.2)
5. Individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary, and identification of necessary changes as appropriate; a description of how the individual

communicates, including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. (Section R.3)

6. The Facility should re-assess the functionality of general-use AAC devices in residences and other environments. (Section R.3)
7. The Facility should ensure comprehensive progress notes related to communication interventions for direct and indirect supports:
    a. Contain information regarding whether the individual showed progress with the stated goal;
    b. Describe the benefit of device and/or goal to the individual;
    c. Report on whether there is consistency in implementation; and
    d. Identify recommendations/revisions to the communication intervention plan, as indicated, related to the individual's progress or lack of progress. (Section R.3)
8. The Facility's monitoring policy for communication devices should include:
    a. Monitoring for the use of communication adaptive equipment in multiple environments (i.e., home, day program, work);
    b. The process for identification, training, and validation for monitors;
    c. The process to establish inter-rater reliability; and
    d. A process for data trend analysis and utilization of findings to drive training and problem resolution (i.e., individual and systemic). (Section R.4)
9. The Facility's monitoring reports should address, at a minimum, the following indicators:
    a. Compliance with established monitoring frequency;
    b. Equipment presence;
    c. Equipment in working order;
    d. Equipment used in various environments; and
    e. In the case a problem was identified, there was evidence of resolution. (Section R.4)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Section S Presentation Book, developed by Tracey Snow Murphy, Director of Residential Services; o For Section S.1, Functional Skills Assessments (FSA), Personal Focus Assessments (PFA), Individual Support Plans, Skill Acquisition Plans (SAPs), and SAP data and monthly Integrated Progress Notes for the last three months, as available, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201; o For Section S.1, Dental or Medical Desensitization Skill Acquisition Plans for: Individual #114, Individual #135, Individual #3, Individual #119, and Individual #16; o For Section S.2, Functional Skills Assessments, Personal Focus Assessments, and Individual Support Plans, and Vocational Assessments as available, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201; and o For Section S.3, Skill Acquisition Plans, as available, for: Individual #185, Individual #73, Individual #279, Individual #114, Individual #251, Individual #241, Individual #125, Individual #61, Individual #30, Individual #276, Individual #7, Individual #135, Individual #315, and Individual #201. ▪ **Interviews with**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 10/1/12; o Tracey Snow Murphy, Director of Residential Services, and Paul Thomas, Director of Active Treatment/Recreation, on 10/2/12 and 10/3/12; o Paul Thomas, Director of Active Treatment/Recreation; Rodshadi Moore, Active Treatment Supervisor; Adrian Richardson, Active Treatment Coordinator; Robbie Walker, Active Treatment Coordinator; and Erika Flores, Active Treatment Coordinator, on 10/2/12; o Tracey Snow Murphy, Director of Residential Services; Paul Thomas, Director of Active Treatment/Recreation; Christiana De Los Santos, Qualified Developmental Disabilities Professional Educator; Marc Lopez, ISP Technician; Sandra Kennedy, QDDP Coordinator; Jim Forbes, Director of Behavioral Services; and Carolyn Milton, Assistant Director of Behavioral Services, on 10/3/12; o Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; and George Zukotynski, State Office Coordinator for Psychology/Behavioral Services, on 10/3/12;

	○ Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services; George Zukotynski, State Office Coordinator for Psychology/Behavioral Services; Bob Robbins, QA/QI Program Compliance Monitor; Tracey Snow Murphy, Director of Residential Services; Marilyn Foster, QA/QI Program Compliance Monitor; and Dawn Ripley, Director of Quality Assurance, on 10/3/12; ○ Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 10/4/12; ○ Jim Forbes, Director of Behavioral Services; Carolyn Milton, Assistant Director of Behavioral Services, and Texas Tech faculty and students, on 10/4/12; ○ Tracey Snow Murphy, Director of Residential Services, on 10/4/12; and ○ Mary Ortiz, Director of Competency Training and Development, on 10/5/12. ▪ **Observations Conducted**: ○ Psychiatric Clinic, on 10/2/12; ○ Staff training at Violet (523), on 10/2/12; ○ Staff training at Willow (520), on 10/3/12; ○ Behavior Support Committee Peer Review Meeting, on 10/4/12; ○ Observation of SAP Integrity Check at Birch (514), on 10/4/12; and ○ 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: ▪ Aspen (513), on 10/1/12; ▪ Birch (514), on 10/1/12 and 10/4/12; ▪ Elm (515), on 10/1/12; ▪ Willow (520), on 10/2/12; ▪ Gym (512), on 10/2/12; ▪ Oak (518), on 10/2/12; ▪ Maple (517), on 10/2/12; ▪ Fir (516), on 10/2/12; ▪ Zinnia (528), on 10/3/12; ▪ Iris (527), on 10/3/12 and 10/4/12; ▪ Violet (523), on 10/3/12; ▪ Tulip (526), on 10/3/12 and 10/4/12; ▪ Pine (519), on 10/5/12; ▪ Lily (524), on 10/5/12; ▪ Education and Training Center (511), on 10/5/12; ▪ Aspen (513), on 10/5/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 9/17/12. In its Self-Assessment, for each sub-section, 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. For Section S, in conducting its self-assessment, the Facility:

	▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Section S – Habilitation, Training, Education, and Skill Acquisition Programs (Revised August 2010) monitoring tool. At the time of the Monitoring Team visit, verbal reports indicated that the current monitoring/audit tool would be revised in the future. ▪ Used other relevant data sources and/or key indicators/outcome measures. o The current self-assessment contained several additional tools including, review of records (e.g., training rosters), SAP observation forms, active treatment engagement monitoring forms, vocational assessment grading tools, FSA Quality Assessment Tool, as well as several databases (i.e., tracking spreadsheets for vocational assessments, SAPs, engagement, program observations, NEO training rosters and competency scores). ▪ The Facility consistently presented findings consistently based on specific, measurable indicators. ▪ However, the Facility did not consistently measure the quality as well as presence of items. ▪ The Facility did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility did not rate itself as being in compliance with any sub-sections of Section S. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Progress was noted in the continued development of skill acquisition plans (SAPs) as well as in the training of staff in their development and implementation. However, although improved, concerns remained regarding the quality of these plans and how targeted needs were identified and documented. In addition, adequate SAP data collection and monitoring remained problematic. Reports reflected efforts to hire new SAP developers, develop curriculum and review tools to ensure the quality of SAPs, implement trainings, and develop a system to track their timely completion. Continued efforts were noted in conducting integrity checks of SAPs and engagement observations. However, concerns regarding staff's ability to accurately and reliably implement integrity probes and support adequate levels of engagement were observed. In addition, although improvements in on-campus attendance in vocational and off-home day programs as well as off-campus supported employment were noted, declines were reported in the number of individuals placed in off-campus enclave and competitive employment positions. Minimal progress was noted in the completion of quality and timely functional skills assessments. Similar concerns were noted with the completion of quality vocational assessments, including the use of vocational explorations. However, reports reflected efforts in developing guidelines/training curriculum, quality review tools, and tracking systems to promote quality functional skills and vocational assessments. Slight progress was noted in developing SAPs designed to be implemented in the community. However, community outings, overall, had remained unchanged and minimal for individuals in some residential programs.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Progress was noted in the continued development of Skill Acquisition Plans (SAPs) and continued training of staff to implement these programs. However, concerns regarding their quality remained. The Monitoring Team's previous reports noted the continued revision of the SAP format, as well as the evolving process of developing, training, and implementing SAPs. In the past, a rubric (i.e., "Required Elements of Skill Acquisition Programs") was developed to assist developers (psychologists) in ensuring that all the critical elements of effective skill acquisition were included in the SAPs. In addition, prior documentation indicated that psychologists were re-trained in the developing revised SAPs, including the use of this self-monitoring tool. Although improvement was noted at the time of the Monitoring Team's previous review, it was evident that all of the sampled SAPs were missing one or more central elements critical to effective skill programming. Currently, provided documentation indicated continued development of SAPs as well as substantial trainings of direct support professionals. Currently, a sample of completed plans from 14 individuals who had an Individual Support Plan meeting since the Monitoring Team's last visit were selected for review. Overall, a total of 55 SAPs provided for 14 individuals were briefly reviewed, and it was found that approximately four (range of two to eight) SAPs were developed, on average, for each individual sampled. In addition, previously developed "SPOs" also appeared to still be in place for two of the individuals selected (i.e., Individual #61 and Individual #276). In an effort to more closely examine the quality of current skill plans, one SAP was randomly selected from each individual and reviewed. These are identified below. In addition to each SAP identified, the available Functional Skills Assessments (FSA), Personal Focus Assessments (PFA), Individual Support Plans, Psychological Assessment, monthly Integrated Progress Notes, and data sheets, for the last three months, as provided, were reviewed and were the basis of the subsequent results: ▪ The SAP for Individual #185 targeting choice making; ▪ The SAP for Individual #73 targeting communication; ▪ The SAP for Individual #61 targeting medication identification; ▪ The SAP for Individual #279 targeting money management; ▪ The SAP for Individual #114 targeting dental desensitization; ▪ The SAP for Individual #251 targeting money management; ▪ The SAP for Individual #241 targeting hand washing; ▪ The SAP for Individual #125 targeting change making; ▪ The SAP for Individual #30 targeting showering; ▪ The SAP for Individual #276 targeting bathing; ▪ The SAP for Individual #7 targeting walking (pedometer);	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ The SAP for Individual #135 targeting dental desensitization; ▪ The SAP for Individual #315 targeting picture identification; and ▪ The SAP for Individual #201 targeting dressing. Of the 14 SAPs reviewed, the following was observed: ▪ Eight (57%) had adequate behavioral objectives. Those SAPs with inadequate objectives included Individual #61, Individual #114, Individual #125, Individual #276, Individual #7, and Individual #315. ▪ Nine (64%) had an adequate task analysis. Those SAPs with inadequate task analysis included Individual #185, Individual #73, Individual #125, Individual #30, and Individual #276. It should be noted that all of the SAPs operationally defined the targeted behaviors using the current task analysis. Consequently, if the task analysis was inadequate, the operational definition of the target response(s) was also viewed as inadequate. ▪ Twelve (86%) had an adequate description of necessary materials or required setting. Those SAPs with inadequate or unclear information included Individual #279 and Individual #251. ▪ Eleven (79%) had an adequate description of the schedule of implementation. Those SAPs with insufficient or unclear information about when to implement included Individual #61, Individual #279, and Individual #251. ▪ Eight (57%) had sufficient opportunities for learning to occur. Those SAPs with insufficient or unclear information about learning trials included Individual #61, Individual #279, and Individual #251. ▪ Thirteen (93%) described relevant discriminative stimuli. The exception was the SAP for Individual #114. ▪ Fourteen (100%) contained teaching descriptions. However, concerns were noted and described below. ▪ Three (21%) conspicuously identified the type of chaining (forward, backward, or total task) utilized in the SAP. This included the SAPs for Individual #251, Individual #30, and Individual #7. ▪ Twelve (86%) described mastery criteria for moving onto another step within the task analysis. The exceptions were two plans that utilized total task presentation (i.e., Individual #7 and Individual #251). ▪ Fourteen (100%) adequately described specific consequences for correct responding. ▪ Thirteen (93%) adequately described specific consequence for incorrect responding. The exception was Individual #114. ▪ Fourteen (100%) identified the use of reinforcers following correct responding. However, as described below, these typically only involved social praise. ▪ Fourteen (100%) identified plans for generalization and maintenance. However, as described below, concerns were noted.	

#	Provision	Assessment of Status	Compliance
		▪ Fourteen (100%) contained documentation instructions. However, as noted below, concerns regarding the frequency of data collection remained. ▪ Fourteen (100%) included a criterion for review if limited or no progress was noted. Overall, the reviewed SAPs demonstrated continued improvement. The revised SAP format appeared to continue to facilitate adherence to the provision of critical elements necessary for effective skill programming. However, based on the sample reviewed, concerns remained. Examples of these concerns are noted below: ▪ For most of the SAPs, rationales did not typically identify a specific assessment that identified the need for the targeted skill programming. ▪ Identified discriminative stimuli, at times, did not appear to correspond to the skill. For example, the cue for Individual #114 in teaching him to keep his mouth open (for longer durations) was: "It's time to work on going to the dentist." ▪ Identified discriminative stimuli appeared to include only verbal responses from staff. The Facility should consider other types of cues that might be more naturalistic, foster more independence, and/or lessen the likelihood of prompt dependence, especially to verbal prompts. ▪ The Facility should include more specification around the materials needed or the setting required for completing SAPs. For example, it was unclear how the identified materials (i.e., " … glasses, a sani-wipe, a trash can and his wardrobe drawer") were related to the SAP of money management for Individual #61, or why Individual #251 "… will need to make a purchase" for the SAP of coin identification. ▪ At times, behavioral objectives were inadequate. For example, the objective did not indicate how many responses would be needed at the independent level for individual #315, which step(s) would need to be completed for "… 7 of 8 consecutive session" for Individual #114, or how many times the correct response would need to be completed for Individual #125. In addition, behavioral objectives did not always accurately reflect the skill being targeted (e.g., Individual #276) or was too vague (e.g., "[Individual] will set her pedometer … ") to identify which step(s) of the task analysis were targeted in the criterion (e.g., Individual #7). ▪ The Facility should consider removing initial prompt levels, except "independent" or those that may always be necessary from behavioral objectives to avoid having to re-write the SAP when the criterion is reached (i.e., less intrusive prompt level is being used) (e.g., Individual #185 or #73). ▪ Task Analysis steps should specify the required response of the individual not the staff (e.g., Individual #185 and Individual #276) and include sufficient detail to assist with teaching a complex skill. For example, "groups the correct amount of change" is likely inadequate specification for correctly making change (i.e.,	

#	Provision	Assessment of Status	Compliance
		Individual #125) and "help him adjust the water so its proper temperature," while important, does not provide the specification necessary to teach the required skill (i.e., Individual #276). ▪ Steps of the task analysis typically differ across the responses of the individual and not across differences in presented stimuli or correction procedures. For example, the steps for Individual 185 reflected differences in stimuli presented and not differences in responding of the individual. ▪ For many individuals, the opportunity to work on identified SAPs appeared inadequate (e.g., once a week for Individual #125 and Individual #135) or unclear (e.g., Individual #279, Individual #251, Individual #30, and Individual #7). ▪ At times, the prompting hierarchy following an incorrect response was missing or inadequate (e.g., Individual #114, Individual #30, and Individual #315). ▪ At times, information was included in sections that appeared problematic. For example, correction procedures were found within the "cue" section in the SAP for Individual #185. These instructions would be better placed with other error correction procedures, and should include specific detail when instructing staff which trial is documented. ▪ It appeared that highly preferred reinforcers were provided following completion of the response without regard to whether or not additional prompts were required (e.g., Individual #315 and Individual #201). ▪ It might be helpful to staff, who are learning about types of chaining, to have the type (forward, backward, total task) conspicuously identified on the SAP. In addition, it was not always clear to the Monitoring Team why a particular chaining strategy was utilized. That is, "reverse chaining" was identified on a showering SAP for Individual #30, and it was unclear how this strategy would be more helpful in reducing "prompt dependency" than another strategy. In this example, staff directions did not appear to reflect backward chaining. ▪ Prompting strategies were often vague, confusing, or seemingly counterproductive. For example, the descriptor "least-to-most" was utilized for most of the SAPs reviewed, and, when more specification was provided, it was not evident that prompt levels were correctly described (e.g., Individual #30). ▪ Although strategies promoting the utilization of differential reinforcement appeared much improved, the use of robust reinforcers (other than social praise, smiling) was not typically observed. ▪ Although mastery criteria within objectives and task analysis were identified in all of the SAPs reviewed, the criterions varied considerably. The Facility should consider standardizing criterions to facilitate more effective review, when appropriate. ▪ Although IDT meeting and/or revision criterion were identified in all of the SAPs reviewed, most included four to eight sessions without progress. Given current	

#	Provision	Assessment of Status	Compliance
		observations of data collection and review, this criterion appeared unrealistic. Documentation was examined to determine if the identified SAPs were based on individuals' needs as identified in the ISP or available assessments including the FSA, PFA, and/or psychological assessment. It should be noted that ISPs were either outdated or unavailable for Individual #315 and Individual #279, respectively, and were not reviewed. Based on the 14 individuals, it appeared that needs related to the SAPs were identified in 10 (71%) individuals' ISPs. The exceptions were the ISPs for Individual #279 (unavailable), Individual #30, Individual #276, and Individual #315 (outdated). Further examination of available documentation was attempted to determine if the identified SAPs were based on specific assessments. However, this was challenging, because FSAs for four (29%) individuals were either not provided or missing substantial numbers of pages of the assessment. In addition, only two (14%) SAPs included specific reference to a completed assessment in their rationale sections (i.e., Individual #73 and Individual #125). Overall, based on review of FSAs, it appeared that specific recommendations for SAPs based on identified needs were evident for two (14%) of individuals sampled (i.e., Individual #73 and Individual #241). Data related to each SAP as identified above, including the last three months of data as well as monthly Integrated Progress notes, as available, was reviewed. Of this sample, data for only six (43%) of the individual SAPs was available for review. Conversely, no data was available for eight (57%) of the individual SAPs. When data was available, however, it was substantially inadequate. That is, based on this sample, three months of data was provided as requested for only one (7%) of the selected SAPs (i.e., Individual #73). In addition, only seven (50%) of those individuals sampled had monthly Integrated Progress notes available for review. Conversely, seven (50%) did not have any Integrated Progress notes available for review. When these monthly progress notes were available, they were also substantially inadequate. That is, based on this sample, three months of progress notes was provided as requested for only one (7%) of the sampled individuals (i.e., Individual #251). It should be noted, that when monthly notes were provided, they seldom included any quantitative data on SAP progress. Indeed, graphs reflecting progress on SAPs was only provided in one sampled progress note, and as noted in the Monitoring Team's previous reports, the information on the graph was unintelligible. Consistent with findings of the Monitoring Team's previous reviews, the collection and monitoring of skill acquisition data continued to be inadequate. An additional sample of medical and dental desensitization programs was reviewed to determine their quality. This review was similar to that completed for the SAPs as identified above. In addition to the two dental desensitization plans already reviewed (i.e., for Individual #114 and Individual #135), three additional desensitization plans were selected. Consequently, this sample included a total of five SAPs, including three	

#	Provision	Assessment of Status	Compliance
		targeting dental desensitization (i.e., Individual #114, Individual #135, and Individual #3) as well as two targeting medical desensitization (i.e., Individual #16 and Individual #119). Of the five desensitization SAPs reviewed, the following was observed: ▪ Two (40%) had adequate behavioral objectives. Those SAPs with inadequate objectives included Individual #114, Individual #16, and Individual #119. ▪ Two (40%) had an adequate task analysis. Those SAPs with inadequate task analysis included Individual #3, Individual #119, and Individual #16. It should be noted that all of the SAPs operationally defined the targeted behaviors using the current task analysis. Consequently, if the task analysis was inadequate, the operational definition of the target response(s) was also viewed as inadequate. ▪ Four (80%) had an adequate description of the schedule of implementation. The exception was the SAP for Individual #119. ▪ Three (60%) had sufficient opportunities for learning to occur. Those SAPs with insufficient or unclear information about learning trials included Individual #135 and Individual #119. ▪ One (20%) described relevant discriminative stimuli. Those with unclear or inadequate discriminative stimuli included Individual #114, Individual #135, Individual #3, and Individual #16. ▪ Five (100%) described mastery criteria for moving onto another step within the task analysis. ▪ Five (100%) adequately described specific consequences for correct responding. ▪ Four (80%) adequately described specific consequence for incorrect responding. The exception was Individual #114. ▪ Five (100%) identified the use of reinforcers following correct responding. However, although individualized reinforcers were identified for Individual #16 and Individual #119, instructions were not provided as to when to deliver the reinforcer or what item(s) were "dietary approved." ▪ Four (80%) identified plans for generalization. The strategies identified for Individual #16 were inadequate. ▪ Five (100%) included a criterion for review if limited or no progress was noted. Overall, the findings for desensitization plans were consistent with the examination of SAPs as reported above. 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. As noted in the Monitoring Team's previous report, skill acquisition Program Observation probes were completed to estimate staff knowledge and skills in implementing SAPs. At that time, it appeared the format was recently revised. Although, it was unclear from previous data how many total observation drills were conducted,	

#	Provision	Assessment of Status	Compliance
		summary data (from November 2011 through February 2012) revealed average monthly estimates ranging from 55% to 100%. Currently, data from skill acquisition program observation probes completed from April 2012 through July 2012 was provided for review. It remained unclear, based on review of data provided within the "Skill Acquisition Program Observation" document, if the presented scores were collapsed across shifts and how many total observation drills were conducted. However, summary data (from April 2012 through July 2012) revealed average estimates ranging from 45% to 100%. Currently, it appeared that the format was revised since the Monitoring Team's previous visit in line with the Monitoring Team's previous feedback. That is, it appeared that items were revised to target how well staff identified the correct training step and to ensure appropriate responding (prompting) following an incorrect response. However, the format could still be improved by increasing the number of items and targeting additional elements of the SAPs, including assessing whether or not staff utilized the correct discriminative stimulus and ensured differential reinforcement following incorrect responding. That is, the closer the rubric reflects all of the critical elements within the SAP, the more comprehensive the estimate of integrity of implementation. It should be noted that the Monitoring Team's direct observation of the completion of a program observation probe while on-site evidenced significant concerns regarding the active treatment staff's ability to accurately and reliably implement these integrity probes. At this time, the accuracy of the above data was questionable. It is strongly recommended the Facility re-train all of the active treatment staff in the completion of these probes before conducting any additional observations. In addition, the Facility should demonstrate, through initially robust and subsequently ongoing regular inter-rater reliability trials (i.e., comparing scores of active treatment supervisors with active treatment coordinators, and/or authors of the SAPs), a high level of agreement between raters. This data should be collected, summarized, and analyzed over time to ensure that raters continue to demonstrate competency in completing skill acquisition integrity checks. The Monitoring Team looks forward to evaluating this data at the next visit. Currently, reports indicated that Behavioral Services staff would no longer write the majority of SAPs. Four new staff within the Active Treatment and Recreation Department were being hired to take on this responsibility. These new professionals would be primarily responsible for the development, training, implementation, and monitoring of SAPs. Verbal reports indicated that Behavioral Services would continue to take responsibility for SAPs targeting replacement behaviors and desensitization programs. At the time of the recent onsite visit, the Facility was encouraged to hire individuals with experience in developing and writing skill acquisition programs. In addition, efforts were underway to develop tools to ensure the quality of SAPs, revise the curriculum for developing SAPs as well as a system to track their timely completion. Indeed, efforts to more closely monitoring SAP development and submission through	

#	Provision	Assessment of Status	Compliance
		ongoing monitoring and monthly chart audits was evident. Overall, the Facility appeared to be in transition regarding the development, implementation, and monitoring of SAPs. 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*** Aspen / 0:3 / 0:3 / 2:5 / 1:5 / 2:5 / 0:5 Birch / 1:3 / 1:3 / 1:2 / 0:2 Elm / 5:8 / 3:8 Oak / 3:5 / 2:5 Maple / 4:5 / 1:5 / 3:4 / 1:4 Fir / 4:4 / 1:4 Zinnia / 4:6 / 1:6 Violet / 2:2 / 3:2 / 1:2 / 0:2 Iris / 3:7 / 2:7 / 0:2 / 0:2 Tulip / 3:5 / 3:5 / 2:5 / 2:5 Pine / 3:5 / 2:5 According to collected data, during brief residential visits overall engagement was 55%. This reflected a very slight improvement in the estimated level of engagement compared to the previously estimated level (53%) evidenced at the Monitoring Team's last visit. An	

#	Provision	Assessment of Status	Compliance
		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 that appeared to impair active engagement or participation in more structured opportunities for skill acquisition. As reported in the Monitoring Team's previous reports, active treatment staff utilizing the Active Treatment Monitoring/Coaching Tool assessed engagement. This tool was utilized 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, and in general, reported monthly estimates reflecting adequate active treatment. However, there were engagement estimates noted in the Monitoring Team's previous report (based on data from November through February 2012) that appeared inadequate. At that time, monthly active engagement meeting minutes reflected active discussion and problem-solving related to these low scores. Currently, engagement was assessed using the revised Engagement Monitoring Form. Summary documentation indicated that between April and August 2012, approximately 230 monitoring observations were completed. Reported average monthly estimates of engagement were 88%, 90%, 91%, and 90% for April, May, June, and July, respectively. Summary data also evidenced similar engagement estimates reported by QA staff during that same time period. Of note, these scores were vastly different from those the Monitoring Team obtained during its review. It appeared that tracking systems were in place to examine engagement estimates across programs, months, and shifts. In addition, inter-rater reliability scores were provided for the engagement monitoring form. This summary documentation appeared to compare engagement scores of active treatment staff and QA staff. However, verbal reports indicated that the provided summary data might actually compare scores obtained through two different rubrics. The Facility should use the same rubric when examining inter-rater reliability between raters. Since the Monitoring Team's last visit, the Active Treatment and Recreation Departments had been combined. In addition, efforts to revise the SAP development curriculum and integrate the active engagement and SAP implementation training had been initiated. This newly revised curriculum recently was integrated and implemented within NEO training. Indeed, efforts to improve training of staff also recently included a revised NEO and OJT training schedule as well as increased amount of time available for training. Documentation provided revealed a significant amount of training completed on active engagement and the implementation of SAPs. As reported in the Monitoring Team's previous reports, the number of individuals in	

#	Provision	Assessment of Status	Compliance
		vocational programs and on-campus workshops had not changed, and no individuals were engaged in off-campus supported employment. In addition, previous reports evidenced that the number of individuals involved in off-campus enclave work decreased significantly, and the number of individuals employed part-time, either on-campus or off-campus, also had decreased. However, previous reports had evidenced an increase in the number of individuals served in the on-campus Client Worker program, and indicated that one additional individual was placed within a competitive employment position. Currently, according to summary documentation provided (September 2011 through August 2012) as well as verbal reports from the Director of Vocational and Day Programs and the Coordinator of Supportive Employment, in August 2012, the number of individuals in vocational programs had increased. In addition, in June and July 2012, the number of individuals in on-campus day programs (but outside of their homes) had significantly increased. In addition, as of August, three individuals were currently engaged in off-campus supported employment. These results reflected an improvement in these areas since the Monitoring Team's visit. However, no changes were evident in the number of individuals served in the on-campus workshops or in the on-campus Client Worker program. In addition, minimal change was reported in the number of individuals involved in the Enterprise program or placed within off-campus competitive employment positions (as of August, one person was employed). A decreasing trend was noted since September 2011 in the number of individuals supported in off-campus Enclave settings. Overall, improvements were noted in involving individuals into day programs outside of their homes, as well as in getting more individuals in supported employment positions. Currently, according to documentation provided and verbal reports from the Director of Vocational and Day Programs, efforts to improve opportunities for community-based employment and to monitor progress had been initiated. This included the Facility's participation in multiple community fairs and on-campus outreach activities. In addition, a community outreach as well as an attendance committee recently had been developed. The community outreach committee was implemented to improve the number and variety of employment opportunities both on- and off-campus. The attendance committee was developed to improve the attendance of individuals in vocational and program settings. These committees appeared to be a recent change, and the Monitoring Team looks forward to examining the related progress during the next visit. As previously noted, the Facility should continue to strive to identify community-based opportunities, including vendors and others within the systems the Facility utilizes, to trial and ultimately place individuals in supported or competitive employment positions. Successful community-based employment will continue to be an increasing need as more and more individuals are placed in the most integrated work setting.	

#	Provision	Assessment of Status	Compliance
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Some progress had been made 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. However, concerns regarding the quality of various assessments remained. As described in the Monitoring Team's previous reports, the Personal Focus Assessment (PFA) had been implemented to facilitate the identification of individual goals and preferences, as well as the necessary subsequent assessments. At the time of the review, teams recently had begun to use the Preferences and Skills Inventory (PSI) for this purpose. In addition, the Functional Skills Assessment (FSA) 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 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 reviewed, documentation evidenced completion of PFAs for 13 (93%) individuals. The exception was Individual #61, for whom a PFA was not provided for review. It should be also noted that pages were missing from the PFAs of Individual #241 and Individual #201. Of the 14 individuals sampled, 13 (93%) were completed within the last 12 months. Of the 14 individuals sampled, only seven (50%) appeared to be adequately completed. More specifically, the PFAs for seven individuals did not evidence a summary of completed sections and/or did not identify specific assessments to be completed. These included the PFAs for Individual #185, Individual #61, Individual #279, Individual #241, Individual #125, Individual #7, and Individual #201. In addition, it was evident that the PFA was completed and shared with IDT team members prior to the ISP as expected for 10 (71%) of the individuals sampled. More specifically, the "posted in shared drive" date was after the ISP date (or could not be determined) for Individual #185, Individual #125, Individual #73, and Individual #251. Lastly, the PFAs were only signed and dated for seven (50%) individuals. Overall, out of the 14 individuals sampled, it appeared that only five (36%) of their PFAs were current (completed within the last 12 months), complete (included summary and identified assessments for completion), and available prior to the ISP (evidenced by the posted to share drive date). Of the 14 individuals in the sample, documentation evidenced completion of FSAs for only 11 (79%) individuals. More specifically, FSAs were not available for Individual #185, Individual #61, and Individual #279. Of the 14 individuals sampled, 11 (79%)	Noncompliance

#	Provision	Assessment of Status	Compliance
		FSAs appeared to have been completed within the last 12 months. Of the 14 individuals sampled, only seven (50%) appeared to be adequately completed. More specifically, the FSAs for seven individuals did not evidence a summary of strengths/needs and/or offer specific recommendations. These included the FSAs for Individual #185, Individual #73, Individual #61, Individual #279, Individual #114, Individual #251, and Individual #30. In addition, it was evident that the FSA was completed prior to the ISP as expected for only nine (64%) of the individuals sampled. More specifically, FSAs were missing or the posted date of completion was after the ISP for Individual #185, Individual #61, individual #279, Individual #30, and Individual #276. It should be noted that documentation indicated that the FSA was completed late for Individual #276 to replace an earlier assessment (completed in March 2012) that was missing. Overall, out of the 14 individuals sampled, it appeared that only six (43%) of their FSAs were current (completed within the last 12 months), complete (included strengths/needs as well as recommendations), and available prior to the ISP. The above findings continued to evidence that the majority of PFAs and FSAs were not adequately completed. Currently, documentation and verbal reports indicated that the PFA was being replaced with the "Preference and Strengths Inventory (PSI)." This change was concurrent with qualitative revisions in the ISP process and was reportedly initiated in late September 2012. In addition, efforts to ensure the quality and timeliness of completed FSAs had been initiated. More specifically, documentation revealed the development of guidelines for completing FSAs, a new training curriculum, a new monitoring rubric (i.e., "FSA Quality Assessment Tool), and a new tracking system, all designed to facilitate and ensure the development of quality and timely FSAs. Verbal reports indicated that these changes were likely to be initiated in October 2012. At the time of the Monitoring Team's previous report, documentation indicated that efforts to revise current State Office policy with regard to practices related to the completion of vocational assessments had been initiated. At the time of the last review, a new policy described procedures, form instructions (consistent with the revised format), and schedules for administration. 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. This issue had not been resolved at the time of the Monitoring Team's current	

#	Provision	Assessment of Status	Compliance
		visit. Currently, vocational assessments of 14 individuals who had an Individual Support Plan meeting since the Monitoring Team's last visit were reviewed. Of the 14 individuals, vocational assessments were available for 13 (93%). The exception was the vocational assessment for Individual #30 that was not provided as requested. Of the 13 plans currently available for review, 13 (100%) individuals had a vocational assessment completed within the past 12 months. This finding was an improvement based on results reported in the Monitoring Team's previous report. That is, at that time, only 86% of the vocational assessments requested were available for review, and of these, only 67% had been completed within the last 12 months. Because summary documentation provided indicated that approximately 63 vocational assessments had been completed since the Monitoring Team's last visit, a smaller sample of vocational assessments was selected (from the 14 described above) for closer review. This smaller sample of six vocational assessments represented approximately 10% of the vocational assessments completed since the Monitoring Team's last visit and included the review of vocational assessment for Individual #7, Individual #125, Individual #279, Individual #276, Individual #209, and Individual #61. Of the six assessments reviewed, zero (0%) were adequately completed. That is, one or more of the content areas of the assessments appeared inadequate across all of the individuals reviewed. One of the primary concerns was the adequate completion of the summary section of the report. That is, only three (50%) of the sampled vocational assessments had an adequate "vocational/employment" vision section. More specifically, this section contained information that was not reflected anywhere in the assessment (e.g., Individual #279 and Individual #61), and at times, primarily contained content not related to the intent of the section (e.g., Individual #201). In addition, only one (17%) of the individuals had an adequate "work preferences" section (i.e., Individual #125). That is, according to the State Support Living Centers Procedures for completing the vocational assessment, the work preferences section should include "a summary of the individual's preferred work conditions as discovered through the assessment." Examination of remaining five vocational assessments revealed that the primary content in this section was previous work experience and not "preferred" work conditions. Other sections showed similar inadequacies. For example, the absence of any "vocational strengths" for Individual #201 and the basic cut-and-pasted information found in the "supports needed to overcome barriers" section for Individual #276. In addition, content found in "ideas for the future" did not appear to be related to information found in the assessment for Individual #125 and Individual #276. Unfortunately, the one area where the current vocational assessments appeared most limited was the one component central to revised template, specifically, the vocational	

#	Provision	Assessment of Status	Compliance
		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 if any actual on-campus or off-campus explorations were recently completed (i.e., none of the assessments provided any dates of vocational explorations as required). That is, when described, explorations appeared to primarily occur on campus (i.e., Individual #7, Individual #125, Individual #61, and Individual #201). All explorations describing off-campus assessment were proposed to take place in the future (i.e., Individual #276, Individual 361, and Individual #279). In addition, many of the explorations described did not appear consistent with activities or preferences identified in the assessment (e.g., picking up mail and paper for Individual #7; or going to a car wash for Individual #61), or appeared to be the same jobs an individual already participated in (e.g., disassembling paper, shredding for Individual #125). Lastly, off-campus assessment appeared to be limited by the beliefs of the IDT regarding the potential for maladaptive behavior (e.g., the team looking for 30 days of target free behavior for Individual #7). The Monitoring Team wondered, given this case, if the IDT considered that the challenging behavior displayed by Individual #7 might be related to the limited work opportunities on-campus. Currently, according to documentation provided and verbal reports from the Director of Vocational and Day Program, an assessment committee recently had been developed to improve the quality of the vocational assessments. This included promoting the competencies of the assessors, facilitating the identification of vocational visions as well as the completion of explorations, and their timely completion. In July 2012, Instructions/Guidelines for completing the vocational assessments as well as a vocational assessment Quality Scoring Tool was developed to assist with ensuring the quality of the completed assessments. Documentation evidenced the completion of several trainings since the Monitoring Team's last visit as well as performance feedback on a monthly basis to assessors regarding assessments completed (since April 2012). Lastly, a tracking system was implemented to closely monitor completion of vocational assessments. Now that an integrity tool was developed and was being utilized, the Facility should consider including the scores from sampled reviews as an indicator of ongoing performance feedback and coaching as well as quality of the assessment. The Monitoring Team looks forward to examining the progress related to all of these recent changes at the next Monitoring Team visit. 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		

#	Provision	Assessment of Status	Compliance
	Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As previously discussed (with regard to Section S.1 of the Settlement Agreement), evidence indicated that needs related to SAPs were identified in 10 (71%) of the sampled individuals' ISPs. Further examination of available sampled documentation was completed to attempt to determine if the identified SAPs were based on specific assessments. Overall, based on review of FSAs, specific recommendations for SAPs based on identified needs were evident for two (14%) of individuals sampled (Individual #73 and Individual #241). 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
	(b) Include to the degree practicable training opportunities in community settings.	Slight progress was noted in the development of skill acquisition programs 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. More recently, as reported in the Monitoring Team's previous report, of the SAPs sampled, 10% were prescribed to be completed either on- or off-campus. Currently, as previously discussed (with regard to Section S.1 of the Settlement Agreement), available SAPs from the 14 individuals sampled were reviewed. Of the 55 SAPs provided for review, nine (16%) included instructions to promote completion either on- or off-campus. These results indicated that SAPs for nine (64%) individuals could be completed in the community. It should be noted, however, that several individuals had money management SAPs that did not specifically prescribe their completion in the community (e.g., Individual #276, Individual #7, and Individual #135). It should be noted that three (33%) of the SAPs targeting completion in the community, only listed the community setting to promote generalization. That is, the community was listed as a setting under the "generalization" section of the SAP. Because generalization probes are typically conducted less frequently than typical training sessions, it appeared that only six (11%) of the currently sampled SAPs targeted the community for the	Noncompliance

#	Provision	Assessment of Status	Compliance
		majority of prescribed trials. It should be noted that only the SAPs for Individual #315 and Individual #135 had the setting for completion conspicuously labeled (or easily identifiable) on the plan. Overall, current findings reflected a very slight improvement in providing training opportunities in community settings. As observed during the Monitoring Team's previous visit, summary data of community outings from September 2011 through February 2012 reflected an overall decreasing trend with a total range of 54 to 165 outings per month across campus. Current summary data of community outings from March 2012 through September 2012 reflected an overall increasing trend with a total range of 70 to 114 outings per month across campus. Data continued to reflect that several programs typically reported no (or minimal) community outings each month. These included Quail, Sparrow, Iris, Zinnia, and Willow. Overall, given these data, although the trend changed, the number of community outings had remained relatively unchanged over the 11-month period. As reported in the Monitoring Team's earlier reports, a substantial amount of data was provided regarding trips that individuals participated in that facilitated skill acquisition programming. However, there was no summary data available to explain the voluminous data that was collected. More specifically, 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. However, it was noted that attempts to redesign "trip sheets" had been initiated to attempt to monitor the completion of SAPs while in the community. The Facility is encouraged to re-examine the current data collection system to ensure that it will effectively monitor those with SAPs targeted for completion in the community as well as individual performance on these over time.	

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

1. The Facility is strongly encouraged to continue with the development of revised skill acquisition plans (SAPS) for each individual concurrent with their ISP cycle. (Section S.1)
2. The Facility should closely review and revise the training materials related to SAP development to 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. 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)
5. 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)
6. 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)
7. 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)
8. 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)
9. SAPs should include a description of the rationale for its development, including identification of the assessment and need that was the basis for the SAP. (Section S.1).
10. The Facility should revise items on the Program Observation probes 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).
11. The Facility should ensure adequate and timely completion of the PSI and FSA prior to the ISP. (Section S.2)
12. The Facility should continue to implement the new Vocational Assessment with an emphasis on developing vocational exploration (situational assessments) based on assessment findings. (Section S.2)
13. The Facility should continue to ensure 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)
14. 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)
15. 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 In response to request for any updated State or Facility policies, the following statement: "All facility procedures related to transition and discharge remain current and have not been changed since the last review"; o LBSSLC Self-Assessment, updated 9/17/12; o List of individuals referred for placement, undated; o List of individuals who have requested community placement, but have not been referred, undated; o Since the last review, list of individuals not referred due to Legally Authorized Representative (LAR) preference, undated; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed, undated; o Community Placements since 3/1/12; o LBSSLC ISP Dates and Resulting Recommendations for Referral, undated; o Since the last review, a list of educational opportunities provided to individuals, families, 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 onsite review, a list of individuals discharged pursuant to an alternate discharge, undated; o Since the last review, a list of all individuals who have transferred to other SSLCs, undated; o 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, undated;

	○ In response to a request for any individuals had moved to the community since 7/1/02 and who had died, the statement: "There have been no deaths of individuals transitioned from this Facility to the community since 7/1/2009"; ○ A current list of alleged offenders committed to the Facility, undated; ○ Community Placement Report, from 3/1/12 through 8/22/12; ○ 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; ○ Since the last review, copies of documents provided to staff to inform them of community living options; ○ DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; ○ Community Living Discharge Plan, related assessments, sign-in sheet, and most recent ISP for: Individual #197, Individual #257, Individual #121, Individual #221, Individual #237, and Individual #59; ○ Community Monitoring list, undated; ○ Tracking grid of timeliness of supports provided to individuals that have transitioned to the community, undated; ○ Individual Support Plans, and related assessments for: Individual #120, Individual #233, Individual #223, Individual #98, Individual #195, Individual #255, and Individual #257; ○ Pre-Move and/or Post-Move Monitoring Checklists for: Individual #107, Individual #13, Individual #316, Individual #221, Individual #237, Individual #59, Individual #197, Individual #257, and Individual #121; ○ A statement that State Office reviews of CLDPs were not available for Individual #195, Individual #255, and Individual #257; ○ Last 10 monitoring tools completed by: 1) the QA Department; and 2) the Admissions Placement Department, various dates; and ○ Presentation Book for Section T, dated October 2012. ▪ **Interviews with**: ○ Carla Prell, Admissions/Placement Coordinator; ○ Annette Webster, Post-Move Monitor and Guardianship Coordinator; ○ Jennifer Smith, Transition Specialist; ○ Sandra Kennedy, QDDP Coordinator; and ○ Christina De Los Santos, QDDP Educator. ▪ **Observations of**: ○ ISP meetings for the following: Individual #140, and Individual #258.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 9/27/12. In its Self-Assessment, for each sub-section, 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. For Section T in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the

	monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: 1) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options; 2) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Sections 1 and 4 – Planning for Movement, Transition, and Discharge and Alternate Discharges – Review of CLDP; and 3) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post-Move Monitoring. o Although these monitoring/audit tools included indicators relevant to the Facility's compliance with the Settlement Agreement, modifications had been made to the State's systems that were not reflected in the tools. Two examples of this included: 1) changes had been made to the ISP Meeting Guide to structure the discussion about the types of obstacles teams discussed with regard to referrals and transition. This impacted the indicators included in the initial monitoring tool, but the tool had not been changed; and 2) similarly, the post-move monitoring tool had been significantly changed from what was in Appendix C of the Settlement Agreement, and likely changes should have been made with regard to the corresponding monitoring tool for Section T.2. As the Monitoring Team has discussed with the Facility and State, these monitoring tools were not designed for the Facilities to implement wholesale. The Facility is encouraged to make changes to the tools to make them more user-friendly. As this is done, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did not identify adequate methodologies, such as observations, interviews, and record reviews to ensure that all of the staff responsible for auditing used the same methodologies. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size) to provide a sense of whether or not they were representative samples. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. In the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team provided some specific comments on how these could be improved upon. The Admissions Placement Department was meeting monthly with the QA Department, and the revision of the monitoring tools, including the development of adequate criteria and guidelines for the assessment process should be a priority. o With regard to the staff/positions responsible for completing the audit tools, at the time of the review, some changes were being made to the monitoring activities for Section T. With the introduction of the Transition Specialists, they were to play a monitoring role.

	For example, they were expected to begin monitoring 75 percent of the post-move monitoring activities, and the Program Compliance Monitor was expected to monitor the remaining 25%. The Admissions Placement Coordinator and the Program Compliance Monitor continued to each monitor four Living Options discussions monthly. The Program Compliance Monitor continued to monitor Community Living Discharge meetings. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had some experience with developing ISPs, completing transition plans, and/or conducting post-move monitoring, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. This is discussed in detail with regard to Section T.1.f. ▪ Used other relevant data sources and/or key indicators/outcome measures. For example, for Section T.1.b, which addresses education about community options, the Facility had included numbers of individuals that participated in community tours, numbers of individuals and families participating in the Provider Fair, etc. This was valuable information. However, in order for it to be meaningful, it needed to be put into the context of measurable outcome indicators. This would need to be accomplished by identifying baselines, and then setting a goal for what would be considered an acceptable or desirable level of participation. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically: o Self-assessment activities did not consistently measure the quality as well as presence of items. For example, the quality of assessments used in developing CLDPs is essential to compliance with Section T.1.d, but the Facility did not appear to take quality into consideration, just presence and timeliness. o In addition, not all requirements of the Settlement Agreement had been reviewed. For example, nowhere in the Self-Assessment did it appear that the Facility had assessed the quality of the essential and non-essential supports (now pre-move and post move required supports) in the CLDPs. o At times, items that were being measured did not equate to compliance. For example, for Section T.1.b.3, the State Office requirement for assessment for appropriateness for placement required a number of steps that are detailed in the Monitoring Team's report. However, the Self-Assessment did not address these steps, but rather indicated the number of individuals in the sample that participated in their Living Options discussion, and the number of ISPs that had a Living Options Monitoring tool. Neither of these in any way related to the State Office requirements related to assessment. o On positive notes, the findings generally were presented based on specific, measurable indicators, as opposed to overall compliance scores. In addition, the Facility Self-Assessment distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section T: 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.g, which requires the development of an adequate report on obstacles to transition to the community; T.1.h, which requires the Facility to provide a Community Placement Report; T.2.a, related to post-move monitoring; and T.4, related to discharge planning for alternate discharges. Not all of these findings were consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following sub-sections: T.1.c.2, T.1.c.3, T.1.h, and T.4. Largely, the discrepancies related to the Monitoring Team assessing the quality as well as presence of items. For example, T.1.g not only requires submission of an obstacles report, but submission of a report that is based on valid data, provides an adequate analysis of the data, and shows that the Facility and State have reasonably acted to reduce obstacles within its control. ▪ The Facility data identified areas of need/improvement. For these areas of need, the Facility Self-Assessment provided little to no analysis of the information, identifying, for example, potential causes for the issues. In addition, the Facility had not connected 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.
	Summary of Monitor's Assessment: As State Office required, for annual ISP meetings, many, but not all assessments included the assessors' recommendations regarding the individuals' potential to transition to the community. Some limited improvement was seen in relation to ISPs including a summary or conclusion with regard to the professional team members' joint recommendation of whether or not transition to a more integrated setting was appropriate. However, disagreements amongst professional members of the team were not consistently resolved, and some confusion existed about the role of professional team members in making a joint recommendation. Based on observations of ISP meetings, it was not clear that when developing a joint recommendation, the teams were using an interdisciplinary process and considering all team members' opinions about the various supports and services the individuals required, and resolving differences of opinion. Teams continued to struggle with the adequate identification of obstacles to referral. Teams had not yet begun to systematically identify obstacles to transition that individuals encountered after the referral was made. Based on the Monitoring Team's review of action plans to overcome the obstacles, few included measurable action steps, and significant problems were noted with their quality and individualization. In addition, it was unclear whether or not the Facility was regularly reviewing and analyzing the data related to obstacles. As a result, it was unclear if the Facility had developed any plans or taken any action to address obstacles within its control. On a positive note, based on a call with State Office on August 28, 2012, in which the Admissions Placement Coordinator participated, the Level of Need for all individuals transitioning to the community from SSLCs during Fiscal Year 2013 were automatically increased to Level 6. This allowed community providers access to increased funds for meeting the individuals' needs. It was hoped that this might alleviate some of the obstacles to transition. Admissions and Placement Department and Transition Specialist staff were clearly working hard with

	individuals' teams to expand the scope and definition of pre-move and post-move required supports in individuals' CLDPs. Additionally, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. With regard to the measurability of supports, this was an area that required attention, particularly as more complex supports were included in the plans. The Facility had been conducting pre-move monitoring, and this was resulting in better confirmation that pre-move supports were in place prior to the individual's transition to the community. However, as teams identified more extensive lists of pre-move supports, some concerns were noted with regard to the confirmation that such supports were in place. Post-move monitoring had been completed in a timely manner for the majority 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, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Although the Facility had taken some important steps to correct issues, the role of the individuals' teams in this process remained unclear, and, at times, the Local Authority and State likely should have been resolved in the resolution of issues.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR,	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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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. Based on the most recent Community Placement Report, a total of nine individuals had been referred to the community, and three individuals were listed as having been referred to the community for 180 days or more. Two had been referred in February 2012, and one in March 2012. One of these individuals had transitioned to the community the week prior to the Monitoring Team's visit. For the other two, based on discussion with the Admissions and Placement staff, legitimate reasons existed for the delays. For example, the team for one individual had appropriately identified that coordinated behavioral supports needed to be in place before he moved. The provider he had chosen was having difficulty providing such supports to other individuals that had transitioned. Working in conjunction with his advocate, the team had reasonably recommended that he visit other providers, and more work was being done to identify supports that would meet his needs. It was positive that the team had taken this important step of evaluating whether or not proper supports would be in place when he transitioned to the community, and to delay the process when this was not the case. As the Monitoring Team has stated in the past, it is of utmost importance that individuals transitioning to the community have the protections, supports, and services they need to lead safe, meaningful, and productive lives. Teams are encouraged to continue to thoughtfully assess the options available to individuals, and assist individuals and their guardians to make informed decisions about the community providers they select. However, as is discussed with regard to Section T.1.g, although teams had begun to identify obstacles to referral, these were limited in scope. Teams also need to identify and document obstacles to transition. It will be important for this information to be captured, analyzed, and submitted to State Office to allow work to be done to overcome such obstacles to the extent possible. The Monitoring Team agrees wholeheartedly with the teams' decisions not to transition individuals until an appropriate configuration of supports and services was identified. However, this likely is an area in which more systemic attention is needed from DADS State Office. On a positive note, based on a call with State Office on August 28, 2012, in which the Admissions Placement Coordinator participated, the Level of Need for all individuals transitioning to the community from SSLCs during Fiscal Year 2013 were automatically increased to Level 6. This allowed community providers access to increased funds for	

#	Provision	Assessment of Status	Compliance
		meeting the individuals' needs. It was hoped that this might alleviate some of the obstacles to transition. As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Local Authority (LA) representative not being at a meeting at which the team decided a referral should be made. However, new rules had been put in place to resolve this issue. The rules were summarized in a document entitled: "Inclusion of the Designated Local Authority during Living Options Discussions." More specifically, the rules had been modified to allow a referral to be made without the LA present. The rules also set forth the parameters for ensuring LA representatives were invited to meetings, notifying the Admissions/Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that with these new rules, an LA representative's inability to attend a meeting would not delay a potential referral. As State Office required, for annual ISP meetings, many assessments included the assessor's recommendation regarding potential to transition to the community. However, some assessments still did not include such recommendations (e.g., psychiatry, some vocational assessments, some speech assessments, and some FSAs). Based on reviews of a sample of ISPs completed prior to the review, teams continued to document in the ISPs their discussion about each team member's recommendation. Some limited improvement was seen in relation to ISPs including a summary or conclusion with regard to the professional team members' joint recommendation of whether or not transition to a more integrated setting was appropriate. During the week of the Monitoring Team's review, teams began to use a revised ISP template that hopefully will assist teams with this process. Based on a review of seven ISPs and observation of two meetings during the week of the Monitoring Team's review (including the ISPs for Individual #120, Individual #233, Individual #223, Individual #98, Individual #195, Individual #255, and Individual #257; and the ISP meetings and related documentation for ISP meetings for the following: Individual #140, and Individual #258), the following was found: ▪ Of the nine ISPs reviewed or meetings observed, none of the individuals were referred for transition to the community. ▪ For these nine individuals, team disagreements were noted in either the ISP document or the assessments for four individuals (44%) (i.e., Individual #258, Individual #140, Individual #120, and Individual #255). It was not clear how the team disagreements had been resolved for any of these individuals. ▪ For these nine individuals, four individuals' ISPs (44%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #223, Individual #195, Individual #257, and Individual #233).	

#	Provision	Assessment of Status	Compliance
		However, at times, the team's justification for its recommendation was unclear (e.g., Individual #195 for whom a cancer diagnosis was cited as the reason she could not be supported in a community setting, or Individual #233 for whom the team was unable to determine his preference). As also noted above, team disagreements often were not reconciled in the final recommendation. 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. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
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:	As noted in the Monitoring Team's previous report, in February 2012, the Facility had updated policies in the Continuity of Services 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 for the last review: "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." Since that time, the revised State Office policy had not been issued. At parties' meetings in July 2012, the parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be	The specific requirements of this provision are discussed below, 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	the 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> The first sentence of this provision states: "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." Based on an agreement of the parties reached on September 7, 2012, substantial compliance with the first sentence of this provision equates to substantial compliance with the following provisions of Section F: Section F.1.d, which requires Facilities to 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; Section F.2.a.1, which requires ISPs to address, in a manner building on the individual's preferences and strengths, each individual's prioritized needs; and Section F.2.a.3, which requires ISPs to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. As noted above with regard to Section F of the Settlement Agreement, although LBSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Sections F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions. 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 served by LBSSLC, 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 pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> The revised ISP format included a section on obstacles identified by the IDT. It included	

#	Provision	Assessment of Status	Compliance
		the State Office's standardized list of obstacles to community referral to assist in the analysis of information collected from IDTs throughout the SSLC system. The State Office had developed a more detailed list of obstacles that teams would use should issues arise as they made efforts to transition individuals to the community. However, at the time of the Monitoring Team's review, teams had just begun to utilize the new format for the ISP. While onsite, the Monitoring Team observed two ISP meetings for which teams used the new format, and reviewed related documentation. Although the new format set forth a specific list of potential obstacles and prompted teams to develop action plans related to obstacles identified, teams still struggled with this process. For example: ▪ For Individual #258, although the team selected obstacles from the list provided, the team did not have an adequate discussion about its reason for selecting "medical issues" as one of the obstacles. For example, although the team had some discussion about an "as needed" injection of a seizure medication as an obstacle, at other points in the meeting team members had indicated the medication had not been used in quite a while. However, this was not part of the team's discussion, and no action plan was developed to determine if the order was still necessary. Beyond this issue related to the PRN medication, the team merely indicated that Individual #258 had seizures and a history of urinary tract infections. The team did not specify exactly what medical supports he would need that they believed could not be provided in the community. In addition, although Individual #258's guardian made some statements about the reason for her wishes that he remain at LBSSLC, the team did not query her about her specific reasons. The team discussed no plans to overcome the obstacles, and no discussion occurred regarding potential education for team members or the guardian about options for supporting individuals with complex medical needs in community settings. ▪ Individual #140's LAR indicated that she wanted him to remain at LBSSLC now, but she wanted to look at other possibilities. Although obstacles were discussed (i.e., need for coordinated and continuous supports, LAR preference), the team did not formally specify them during the meeting. Although an action plan was developed that included his guardian and Individual #140 visiting community options and attending the provider fair, the team did not discuss individualization of the plan to allow specific questions to be answered. For example, the guardian and team had questions about whether or not integrated psychology and communication supports could be provided in the community as they currently were being provided at the Facility. The action plan should have been designed to ensure such questions were answered. In reviewing the sample of seven ISPs as well as observing two ISP meetings and	

#	Provision	Assessment of Status	Compliance
		reviewing related documentation, teams had discussed some obstacles to referral. Of the nine ISPs, all should have had obstacles to referral defined, because none of the individuals had been referred to the community. Of the nine plans, one (11%) adequately defined obstacles (i.e., Individual #233). The problems associated with the obstacles in the plans included the following: ▪ Some identified the individuals' needs as obstacles to referral, as opposed to supports or services not being available in the community to support such needs (e.g., Individual #258 and Individual #195's medical issues without the specific supports the individual needed that could not be provided in the community being defined, and Individual#255's behavior of food foraging, aggression, inappropriate social behaviors); ▪ In two cases, the team did not specifically define the obstacle(s) to referral (e.g., Individual #140 and Individual #120); ▪ When guardians or individuals objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #223 and Individual #257). This is very important information to collect and analyze, but it did not appear it was being captured regularly; and ▪ For one individual, the team's justification for the obstacle was not clear. For Individual #98, the team concluded: "The IDT's determination of the most appropriate Living Option at the current time for [Individual #98] is that [he] should continue to reside at the LubSSLC. This determination is based on [his] preference to continue to reside at the LubSSLC. He has lived at the LubSSLC for almost 39 years and considers it home. The environment is familiar to him and he has established long-term relationships with many people at LubSSLC." However, it is important to note that the team determined in the Rights Assessment that Individual #98 could not provide informed consent in any of the areas listed, including programmatic. He did not have a guardian. The team relied solely on his stated preference in determining whether or not a referral should be made even though the team did not believe he could make an informed decision in this area. In this case, the team also had not made an independent recommendation to the individual regarding community transition. Action plans to overcome the obstacles to referral generally were not adequate. Of the nine ISPs, eight (89%) included an action plan to overcome obstacles identified. Individual #258's team did not discuss or develop an action plan. Of these, none (0%) were adequate. Some of the concerns included: ▪ The plans were not adequately individualized or measurable. Many indicated that the individual would participate in community tours, but the number or tours, the types of programs that would be visited, and/or the specific timeframes in which this would occur were not stated. Many plans merely	

#	Provision	Assessment of Status	Compliance
		stated individuals would attend community exposure tours, attend provider fairs, and be provided CLOIP information, even when these methods had not been effective in the past. Even when teams had put numbers in to make them measurable, these plans showed little thought about what would be meaningful to the individual, how information should be presented, what types of programs would be most important for the individual to see, who should accompany the individual on the tours or to the fairs, individualized methodologies for judging the individuals' reaction, other creative ways that the individual could learn about community options, etc. ▪ In addition, plans to address guardian reluctance were not individualized. As has been noted previously, when a guardian is reluctant, to the extent possible, the related action plans should address the specific issues about which the guardian is concerned. For example, if the guardian were concerned about the behavioral supports available in the community, then more education or research about the individual's options for being properly supported would be appropriate topics for an action plan. Sometimes, the action plans will involve staff action as opposed to guardian action. ▪ For a couple of individuals, the team's inability to determine their preference had been identified as a problem. However, the related action plans did not define a methodology for determining his/her preference, nor were the community exposure tours individualized to address the individual's specific preferences. Similarly, it appeared unlikely that mere attendance at the provider fairs without some structure would result in any additional identification of the individuals' preferences. Finally, at times, obstacles were identified, but no action plans were developed to address them specifically (e.g., medical supports or lack of coordinated behavioral and communication supports). The Facility was not yet documenting obstacles to transition. Although as noted in previous reports, some training had been provided to QDDPs and team members on the State Office list of obstacles to transition, a system for capturing such obstacles during the transition process, in ISPAs or the CLDP documentation, and then entering such information into a spreadsheet or database had not yet been operationalized. Anecdotally, some individuals had encountered obstacles to transition, including, for example, identifying a home in the Lubbock area that could successfully support the individual's intensive behavioral needs. Concerns also had been noted with identifying timely psychiatric services. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. As discussed while the Monitoring Team was on site, this should be viewed as an opportunity to ensure State Office is aware of the types of protections, supports, and services that require attention and/or expansion.	

#	Provision	Assessment of Status	Compliance
		LBSSLC remained at the initial stages of identifying obstacles to referral and transition, and developing plans to overcome such obstacles. This deficiency, in addition to ISPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	At the December 2011 parties' meeting, the Monitors and parties agreed upon a format/outline for assessing this section, which is reflected in this report. As described in previous reports, 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. Based on documentation provided, this had taken a number of forms, but work was still needed to ensure adequate education was provided. The following summarizes the actions taken as well as areas in which additional work was needed: ▪ **Annual provider fairs**: The Facility was now conducting two provider fairs each year. One was held on March 7, 2012, and another recently had been held on September 8, 2012. Prior to the fair, a questionnaire was distributed to residences to assist individuals and staff in asking pertinent questions when interacting with community provider staff during the fair. At this fair, as at the one in March, a Question and Answer Panel was held. Based on some of the feedback obtained through the evaluation process, it was well received. Based on data provided, participants at the September fair included 47 individuals, 10 Legally Authorized Representatives, 23 direct support professionals, 40 "professional staff," and 26 provider staff/guests. Participants were asked to conduct evaluations. Responses were displayed in pie charts, and had been broken down by type of respondent (i.e., individuals/families, staff, and providers/Local Authorities). However, it was unclear if this data had been formally analyzed, and a determination made with regard to whether changes needed to be made to future provider fairs, or if different evaluation questions needed to be asked. ▪ **Education about community options:** Individuals and their guardians also were provided information through the Local Authority CLOIP process. Based on tracking sheets provided, it appeared that this occurred regularly as part of the individual planning process. However, it did not appear that outcomes/measures had been determined and/or data collected regarding the number of individuals and families/LARs who agree to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refuse to participate in the CLOIP process. The only data included in the Presentation Book regarding the CLOIP process related to how	Noncompliance

#	Provision	Assessment of Status	Compliance
		many CLOIP worksheets were completed in a timely manner. Collection and review of additional outcome data would allow the State to evaluate the effects of the process and make changes made to future educational activities. ▪ **Tours of community providers**: 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 be scheduled on the second and fourth Tuesdays of the month. Tours were advertised through a variety of mechanisms, including, for example, articles in the employee newsletter, at self-advocacy meetings, and Family Association meetings. With few exceptions, they appeared to consistently occur at this frequency. Based on raw data the Facility provided, between 3/15/12 and 8/15/12, approximately 45 individual went on community exposure tours. (It is important to note that the raw data provided and represented here was different from that included in the Facility Self-Assessment, which showed higher rates of individuals involved.) At times, these appeared to be large groups of individuals. For example, between seven and 10 individuals as well as staff attended some of the visits. With groups this large, it was unclear how individuals would gain an understanding of what life in a small community program would be like, or how staff could accurately gauge individuals' reactions to a smaller setting. Based on review of individuals' ISPs, at times, teams included this as an action step to provide individuals with greater exposure to options available in the community. However, as discussed in further detail below, such action plans often were not individualized or measurable. In addition, it was unclear if data had been analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individual's specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. It was positive to see that the Facility had begun to document the individual's reaction. However, it was not clear how this information was utilized, or how the various factors that could impact an individual's reactions were assessed (e.g., time of day, staff accompanying the individual, etc.). ▪ **A plan for staff to learn more about community options**: Although LBSSLC had not provided a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals, they had continued to take a number of steps to provide educational opportunities. However, this should be formalized in a plan. On the forms used to track individuals' attendance on community exposure tours, the Facility also was identifying the staff, including their titles that participated in the community	

#	Provision	Assessment of Status	Compliance
		tours, as well as the provider fair. It was not clear if data regarding staff training were being aggregated and analyzed. New Employee Orientation included a component on the most integrated setting. The Admissions Placement Coordinator provided a component of the On-the-Job training for new QDDPs. The Transition Specialist also had begun to attend QDDP meetings, and provide information and training on topics related to the most integrated setting. In addition, in October 26, 2012, the Local Authority was scheduled to provide training on services and supports available in the community. Families, individuals, and staff were invited. ▪ **Individuals and families have opportunities to learn about success stories:** At the recent provider fair, an individual that had recently transitioned spoke. This was a positive way to share an individual's success story. The Facility had not yet addressed the following areas adequately: o The Facility should build upon its initial experience with having an individual present at the provider fair, and include success stories about individuals in newsletters or other forums, and/or have individuals or their guardians present information about their experiences in other forums (e.g., Family Association meetings, or small group settings); o The Facility should provide opportunities for individuals to visit friends who live in community; o As appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; and o If aggregate data showed that families and guardians had similar concerns, then the Facility should use mechanisms to provide information on specific topics. For example, offering specific educational seminars might be useful. ▪ **Education may be provided at Self-Advocacy, house, and Family Association meetings, or other appropriate locations:** 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, the winners of the Poster Contest were announced. The poster contest continued to provide an opportunity for individuals to think about community options and express their ideas through artwork. Everyone living on campus was invited to vote for the winning posters, and the winning poster would be displayed and published. This was a creative way of increasing individuals and staff's awareness of community living options. The Admissions Placement Coordinator also presented at Family Association meetings. Based on the documentation provided, at both the Self-Advocacy and	

#	Provision	Assessment of Status	Compliance
		Family Association meetings the main topic appeared to be announcing the dates for upcoming community exposure tours, and encouraging individuals and their families to attend. This is an area in which an expanded set of topics should be developed an offered. For example, specific types of community supports could be discussed, individual or family members of individuals who have transitioned to the community could be invited back to tell their stories, questions could be solicited and a question and answer period provided, etc. The Facility did yet indicate house meetings were forums in which education regarding community options was occurring. However, Local Authority staff had visited some of the homes and showed a "movie"/DVD about community living options available. This was positive, because it provided an additional educational opportunity, as well as an opportunity for the individuals and LA staff to get to know one another better. ▪ **Regular SSLC meeting with the Local Authority:** Based on interview with staff and review of signature sheets, a group of Facility staff was meeting with Local Authority staff monthly. From the Facility, this generally included the Admissions Placement Coordinator, Post-Move Monitor, QDDP Coordinator, and Transition Specialist. Based on interview, the group discussed upcoming CLOIP encounters, new educational opportunities in which the LA could be involved, and the flow of information back and forth between the LA and the Facility. However, other than data reviewed about the timeliness of CLOIP worksheets, no minutes or other documentation was available to confirm what the group discussed, or decisions or assignments made. ▪ **Individualized Plans:** The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing seven recently completed ISPs and observing two ISP meetings and reviewing related documentation, eight (89%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following concerns were noted: o None of the plans were individualized to address the individual and/or the LAR's particular needs or concerns. The action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance. For example, if an LAR has questions about the specific supports available in the community, identifying providers with	

#	Provision	Assessment of Status	Compliance
		expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. At the time of the review, this had not yet occurred. Creative ideas and brainstorming within LBSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. Some examples of concerns related to the individualization of action plans included: ▪ For Individual #140, the guardian and team had questions about whether or not integrated psychology and communication supports could be provided in the community as they currently were being provided at the Facility. The action plan should have been designed to ensure such questions were answered. ▪ Although a specific and measurable action plan was identified for Individual #120 to attend community exposure tours and provider fairs, it was not individualized. The team indicated it was not aware of Individual #120's preference with regard to transition. However, the action plan did not identify a methodology for determining his preference, nor were the community exposure tours individualized to address the individual's specific preferences. Similarly, it appeared unlikely that his mere attendance at the provider fairs without some structure would result in any additional education for Individual #120 or insight for his team regarding his specific preferences. ▪ An action step was for Individual #257 to attend eight community exposure tours in 12 months. Although this was measurable, it was not individualized (i.e., it was not clear what type of community exposure tours, or what the team expected Individual #257 would gain from this experience, how her response would be evaluated, etc.). o Most of the plans were not measurable, nor did they provide for the team's follow-up to determine the individual's reaction to the activities offered. Many of the plans involved participation in community tours, but did not say how many or when these would occur. No methodologies were included to ensure that the individual and/or guardian's questions were answered (e.g., helping them write a list of questions specific to them, or a staff person assisting with asking questions). No specific strategies were included to obtain the individual's reaction at the time or shortly after an educational	

#	Provision	Assessment of Status	Compliance
		opportunity. o None of the plans indicated whether or not there was a plan the previous year and/or if it was completed. Although the Facility was continuing to complete some of the basic activities related to education and some progress had been made in expanding these opportunities, minimal progress had been made since the last review in individualizing the process. Although more individuals had a plan in their ISP, the plans generally were not individualized or measurable. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility remained out of compliance with this provision.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The Monitoring Team requested for the last 12 months, a list of individuals who had been assessed for placement. In response to this request, LBSSLC submitted a list of individuals with their most recent ISP date, and an indication of whether or not the IDT had made a referral. As State Office required, for annual ISP meetings, many assessments included the assessor's recommendation regarding potential to transition to the community. However, some assessments still did not include such recommendations (e.g., psychiatry, some vocational assessments, some speech assessments, and some FSAs). Based on reviews of a sample of ISPs completed prior to the review, teams continued to document in the ISPs their discussion about each team member's recommendation. Some limited improvement was seen in relation to ISPs including a summary or conclusion with regard to the professional team members' joint recommendation of whether or not transition to a more integrated setting was appropriate. During the week of the Monitoring Team's review, teams began to use a revised ISP template that hopefully will assist teams with this process. Based on a review of seven ISPs and observation of two meetings during the week of the Monitoring Team's review (including the ISPs for Individual #120, Individual #233, Individual #223, Individual #98, Individual #195, Individual #255, and Individual #257; and the ISP meetings and related documentation for ISP meetings for the following: Individual #140, and Individual #258), the following was found: ▪ Of the nine ISPs reviewed or meetings observed, none of the individuals were referred for transition to the community. ▪ For these nine individuals, team disagreements were noted in either the ISP document or the assessments for four individuals (44%) (i.e., Individual #258, Individual #140, Individual #120, and Individual #255). It was not clear how the team disagreements had been resolved for any of these individuals. ▪ For these nine individuals, four individuals' ISPs (44%) included an independent	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommendation from the professionals on the team to the individual and LAR (i.e., Individual #223, Individual #195, Individual #257, and Individual #233). However, at times, the team's justification for its recommendation was unclear (e.g., Individual #195 for whom a cancer diagnosis was cited as the reason she could not be supported in a community setting, or Individual #233 for whom the team was unable to determine his preference). As also noted above, team disagreements often were not reconciled in the final recommendation. Some additional concerns were noted with regard to teams' understanding of this process. These concerns included: ▪ During one of ISPs observed, a member of the Admissions and Placement Department was present. During the team's discussion about its recommendation related to the most integrated setting, when the nurse on the team expressed an opinion about the supports the individual needed related to autism, the Admissions and Placement representative indicated that supports related to autism were not within the realm of nursing and should be addressed by psychology as opposed to nursing. This was concerning because just as when the team is coming to any decision, when developing a joint recommendation related to the most integrated setting for the individual, the team should use an interdisciplinary process and all team members' opinions about the various supports and services the individual requires should be taken into consideration. There will be times when there is disagreement, but such disagreements should be worked through. It is dangerous to carve this out as a discipline-by-discipline decision, and to push team members back into their silos that so much work has been done to break down. ▪ The recommendations included in assessments were not always consistent with what it appeared State Office was requiring. For example, for Individual #258, The SLP assessment did not include a specific statement, but stated: "[Individual #258] is ***not able to verbally communicate wants and needs*** (basic or medical) to communication partners. Therefore, [Individual] would benefit from ***remaining in an environment*** where he has staff available to anticipate his needs and interpret his communication signals." Similarly, the nutrition assessment did not follow State Office protocol, but rather stated: "In my professional opinion, [Individual] would need the above supports for community placement." This did not provide an opinion about whether the individual could be supported in a less restrictive environment. The medical assessment stated: "Based upon the identified needed supports/services in the area of Urology, neurology for his seizures and Nursing and Medical, I believe that these supports and services cannot be provided in a less restrictive setting." However, the physician did not identify specifically what about these routine specialty medical services could not be provided in a community setting. Similarly, the nursing	

#	Provision	Assessment of Status	Compliance
		assessment concluded that: "Based upon the identified needed supports/services in the area of Nursing, I believe that these supports and services cannot be provided in a less restrictive setting. [Individual] requires 24 hour nursing care to maintain optimal health. In my professional opinion, I feel that [Individual] cannot be served in a less restrictive setting. He is at high risk for aspiration, has a seizure disorder, requires assistance and supervision with meals, is fully dependent on [direct support professionals] for transfers and repositioning, etc." This identified the individual's needs, but did not identify which supports the assessor believed specifically could not be provided in a community setting. ▪ At times, teams appeared to base their final recommendation related to transition to the most integrated setting on their inability to determine the individual's preference in the absence of a guardian (i.e., Individual #120 and Individual #98). However, teams then did not state whether they thought they ever could determine the individual's specific preference, and if so, how that would be accomplished. Rather, the teams for these individuals developed general action plans for additional community exposure tours without saying how such activities would be different from past ones, and/or how they would assist the team in determining the individual's preference. For the individuals involved, it also is important to note that elsewhere in the ISP and/or Rights Assessments, the teams had indicated that they believed the individuals could not make informed decisions regarding many decisions, including programmatic decisions. Although as discussed with regard to Section U, the Facility did not yet have an adequate process for determining if individuals could provide informed consent, it was unclear if teams understood what role they ultimately would need to play for individuals that could not make informed decisions. Although it was important to try to determine the individuals' preferences, if the individual could not provide informed consent, many other factors would need to be taken into consideration in the team's decision. 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. As noted above, teams were not consistently following this process, and the Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to	Since the last review, some progress had been made with regard to teams' development of CLDPs. The CLDPs included a wider scope of pre-move and post-move required	Noncompliance

#	Provision	Assessment of Status	Compliance
	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:	supports (it was agreed at the parties' meetings in July 2012 that the terminology "essential and nonessential supports" would be replaced with "pre-move and post-move required supports"), and the supports were often more detailed. However, team members needed to improve the assessments that contributed to the CLDPs, and ensure that a comprehensive set of protections, supports, and services were detailed in the CLDPs. Since the last review, nine individuals had transitioned to the community. Five of these individuals' CLDPs were reviewed (i.e., Individual #197, Individual #257, Individual #121, Individual #221, Individual #237, and Individual #59). This represented 67% of the relevant CLDPs. With regard to the timeliness of the Community Living Discharge Plans, the six plans included documentation to show that they were developed sufficiently prior to the individual's transition. This was determined based on the narrative, and the information included in the CLDP regarding the team's deliberations and discussions, for example, regarding pre- and post-move required supports. The Facility also had added a cover page to the document that listed the dates the team had met to revise the plan. This was a helpful addition. With regard to the timeliness of the development of CLDPs, the Facility had sustained its progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate CLDPs.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Clearly, since the last review, the Facility was making efforts to include more specific supports and services. However, none of the six 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. This had been improved by providing more information about the topics the training would cover. However, the pre-move required supports 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.). ▪ Similarly, the pre-move required supports did not define what level of mastery of the information was required (e.g., classroom training, demonstration of competence, etc.). For example, no indication was provided regarding whether 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,	Noncompliance

#	Provision	Assessment of Status	Compliance
		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., a pre-move required support), or, at a minimum, evidence should be required that the community provider staff have the competencies necessary to safely support the individual (e.g., transfer techniques, or crisis intervention techniques, including physical holds, etc.). ▪ 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. For example, for a couple of individuals the teams included requirements that psychotropic medications not be changed for six months to a year after the individual moved. However, without adequate coordination and discussion between the Facility psychiatrist and community psychiatrist, it was unclear how teams thought this was a realistic expectation. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ The plans 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 (e.g., for individuals who specifically indicated that they liked to walk when they were upset). ▪ A few of the plans included methods for ongoing communication with LBSSLC staff or IDTs. This was one important role that LBSSLC staff could play in assisting the individual to make the transition. However, in other instances where LBSSLC or community provider staff should have played such a role, adequate supports were not identified. For example, in his personal interview, Individual #221 clearly indicated that he did not like "new staff." However, no process was put in place for him to get to know staff at the new setting. He only had one three-day visit to the new site. There were no action steps to have him go back to visit, for community provider staff to visit him at LBSSLC, for familiar staff to be present at the community home for a transition period, etc. 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	

#	Provision	Assessment of Status	Compliance
		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 pre- and post-move required 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 pre- and post-move required supports individuals required. The Facility remained out of compliance with this provision.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	All six of the CLDPs reviewed (100%) generally included a date of completion, as well as the specific name of the Facility or provider staff responsible for the completion of the actions identified. As noted below, however, some emerging concerns were noted to which the Facility should pay attention. The Facility was found to be in substantial compliance with this provision. However, in order to remain in substantial compliance, the Facility is cautioned to ensure that as the supports included in CLDPs expand that adequate timeframes and persons responsible are assigned. The Monitoring Team had begun to see some supports for which adequate timeframes and specific staff responsible had not been adequately detailed. This likely will become more of an issue going forward as more complex supports are included in the CLDPs. For example, implementation of plans, such as PNMPs, health care plans, and PBSPs, will require a start date, and then a frequency for a number of different aspects of plan implementation (e.g., daily implementation and documentation, monthly review by a clinician, at least annual review or as needed modifications to the plan, etc.). In a number of cases, these activities were assigned one date and one person responsible. The person responsible often was the nurse or community provider program coordinator. This list also will need to expand. For example, at times, others will be responsible for oversight of a plan (e.g., psychologist, therapist, etc.). This will require a lot more detail regarding both timeframes and persons responsible. In addition, at times, it was unclear how teams had determined timeframes for completion, and whether or not this was based on the individual's need or the availability of supports. For example, some medical and dental supports as well as therapy supports were scheduled for completion months or even a year into the future, when this did not seem consistent with the individual's needs (e.g., one-year deadlines for dental services for Individual #257, or dietary services for Individual #59). In order to maintain substantial compliance for the next review, the Facility will need to clearly assign implementation dates/timeframes for each element of the activities identified, as well as persons responsible. Completion dates should be clearly in line with	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		the needs of the individual.	
	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 and/or the narrative in the CLDP, it appeared that the teams reviewed the CLDP with the individual or guardian prior to the individual's transition. For five plans reviewed sign-in sheets were provided, and for one, the guardian's presence on the telephone was documented in the narrative (100%). 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 and some improvement was seen with some assessments, the quality (i.e., comprehensiveness) of most of the assessments was significantly lacking. With regard to timeliness, for six of the six individuals' CLDPs reviewed (100%), it appeared that assessments that were submitted had been updated within the 45-day timeframe. However, at times, assessments were missing from the packages of assessments, particularly dental assessments. In addition, at times, assessments were completed after the team met to finalize the CLDP. Although this technically fell within the 45-day timeframe, it was unclear how such assessments were helpful to the team in developing a complete CLDP in a timely manner. The quality of these assessments was lacking. None of the six 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 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,	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.). However, it should be noted that some of the OT/PT assessments had begun to include a more comprehensive list. For example, the OT/PT assessment for Individual #257 was a good example of an assessment that detailed the supports individual required. This was very positive to see. Unfortunately, the team had not included all recommendations in the pre-move or post-move supports sections of the CLDP, and no justification was provided for not including them. ▪ Generally, 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. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessment is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. In the last report, the Monitoring Team noted that no progress had been made in this area. However, since then, progress definitely was being made. Admissions and Placement Department and Transition Specialist staff were clearly working hard with individuals' teams to expand the scope and definition of pre-move and post-move required supports.	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	Additionally, 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. However, to make use of these improvements, teams will need to use the ISPs more effectively when developing CLDPs. In some cases, important supports that now were included in individuals' ISPs were not addressed in transition plans. However, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. Although the measurability of supports was improving, this was an area that required attention, particularly as more complex supports were included in the plans. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. Even when teams identified important preferences of the individuals in the interviews conducted, these were not meaningfully translated into pre-move or post-move supports. This lack of comprehensive identification of supports 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. In none of the six plans reviewed (0%) was a comprehensive set of pre-move and post-move required identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the progress as well as the general concerns noted: ▪ As noted above, the scope of the protections, services, and supports included in CLDPs had improved. However, many supports were not included. As the Monitoring Team previously has recommended, teams should visualize the individual with no supports at all, and then identify each and every support that was needed to assist the individual to be successful in a particular community environment(s). Once these were listed, the individual's CLDP needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. ▪ 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 "psychologist to monitor behavioral issues and modification of behavior programming," or "establish services with a dietician" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at LBSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community. For example, for an individual that had a number of nursing supports or habilitation therapy needs,	

#	Provision	Assessment of Status	Compliance
		work needed to be done with the community providers to determine how equivalent supports would be provided in community settings where nurses were not stationed in each home, and habilitation therapists generally were external vendors. ▪ 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. For at least one individual (i.e., Individual #257), the OT/PT assessment included a recommendation to require training for community provider staff on triggers related to the individuals' risks, documentation of the triggers, and communication to nursing personnel should they occur. However, the team did not include these supports in the plan, and no justification was provided for not including them. Although the therapist had correctly identified an important set of supports, the team failed to include them in the plan, placing the individual at risk. ▪ 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, although teams had begun to reference nursing care/health management plans in CLDPs, little, if any, detail was provided about how they would be implemented in the community. For example, the role of nursing staff in the community versus direct support staff was not defined. It was not at all clear what level of nursing staff (i.e., RN or LVN, and/or the amount of time per day/week) was necessary. Likewise, individuals who were receiving habilitation therapies supports at LBSSLC did not have functionally equivalent supports identified in their CLDPs. Therapists at LBSSLC played a number of roles, including staff training, provision of direct therapy, monitoring of programs, monitoring of equipment, etc. Other than initial appointments with therapists in the community, it was unclear how these functions were being transitioned. ▪ 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. For example, as noted above, if triggers related to risk were being monitored at the Facility, these should not be left out of the CLDP without adequate justification. Similarly, staff at the Facility were monitoring for side effects of medication, tracking and reporting data to the psychiatrist on symptoms of psychiatric disorders, attending medical	

#	Provision	Assessment of Status	Compliance
		appointments with individuals to help communicate relevant information, fixing adaptive equipment or obtaining such repairs, etc. These are just a few examples of supports and services that required a plan for how they would be transitioned to the community. ▪ 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 had begun to identify the need for treatment plans be implemented (e.g., PBSP, nursing care plans, health management plans, diets, exercise programs, etc.). However, this was not consistent. Just as one example, some CLDPs indicated PBSPs should be implemented, while others did not (e.g., Individual #221). ▪ A number of the individuals reviewed had specific health care indicators that needed to be monitored and reported (e.g., input/output, meal refusals, psychiatric symptoms, etc.). Some plans had begun to include supports to address these needs. However, this again was inconsistent. For example, no indicators were identified for behavioral or psychiatric treatment plans. For some health care plans, supports were included to weigh individuals monthly, take blood sugar readings weekly, monitor input, maintain bowel movement logs, etc. However, of significant concern, it was unclear what would happen when specific criteria were met. As noted above, because the CLDPs did not define the staffing that needed to be available (e.g., direct support professionals, nursing staff, etc.), and/or who was responsible for what, it remained unclear what protections were in place for when health care indicators required further review. For example, individuals in the sample had issues requiring monitoring such as diabetes, low and high weight status, use of medications that could cause dehydration, etc. For none of these had teams identified the parameters that would require notification of a nurse or physician. ▪ Since the last review, a couple of individuals' CLDPs identified the need for a crisis intervention plan. However, review of these plans showed them to be inadequate. For both Individual #197 and Individual #121, the plans addressed what to do when signs that the individual might be heading for crisis were observed (i.e., call and request an appointment with the individual's counselor and/or psychiatrist). Although this was important, neither of the plans addressed what would happen if the individual escalated into crisis. Given that a number of individuals that recently had transitioned had police contact and one had repeated incarcerations as a result of provider staff not being able to handle crisis situations and instead calling the police, it was extremely concerning that better crisis planning was not occurring. This should include, but not be limited to defining how the current methods for dealing with crises at the Facility need to be modified in a community setting, ensuring provider staff are	

#	Provision	Assessment of Status	Compliance
		trained/certified in approved psychological and physical management techniques, ensuring the providers have adequate staffing to address a crisis situation, identifying potential options other than calling the police such as crisis intervention teams, working with the police in the area to understand accommodations necessary for individuals with developmental disabilities, including enlisting the help of the Protection and Advocacy organization to work with the police, etc. ▪ Direct support staffing ratios and requirements were not specified. What was specified did not provide specific guidance regarding the individual's staffing requirements. For example, "24-hour awake staff" was not helpful in ensuring the individual who was the subject of the transition plan received adequate staffing supports. Depending on the ratio and other staff responsibilities, "24-hour awake" staffing in no way guarantees that the individual will remain safe, and be adequately supervised. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). ▪ In reviewing assessments, albeit incomplete, a number of recommendations were not specifically addressed in CLDPs. However, this had improved from previous reviews. ▪ 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. ▪ Previously, CLDPs included a section in which the skill acquisition programs on which the individual was working were noted. The Monitors consistently recommended that these become part of the post-move supports. The CLDPs reviewed did not include this section, and the post-move supports only occasionally indicated that "informal" implementation of programs would continue in the community. It is unclear why an individual's learning to increase his/her independence would cease when he/she moved to the community. Teams offered no justification for discontinuation of the programs, or substitution of other programs to increase the individual's independence. Of additional concern, the "evidence" column in the CLDPs was generally very weak.	

#	Provision	Assessment of Status	Compliance
		Often, the evidence identified was not adequate to determine that the support actually had been provided (e.g., monitoring the Bowel Management Plan to review the support to "continue to follow her Bowel Management Plan to monitor constipation" did not provide evidence that staff were following the plan; looking at a food and fluid intake sheet was not adequate to confirm staff were providing the correct diet texture; and similarly, the evidence of "Nursing documentation" for following an individual's PNMP was inadequate as opposed to observation of staff implementing the plan, or monitoring reports to show the community provider was checking to make sure it was followed). Since the last review, some important improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. However, the CLDPs continued to be missing many necessary protections, services, and supports. Of note, all of the CLDPs reviewed included the following statement: "It was agreed to hold [Individual's name] bed at Lubbock SSLC for 30 days to allow time for his adjustment to his/her new home." This was not a statement previously included in CLDPs, and it had been the Monitoring Team's understanding that beds could not be held. More information will be requested from State Office regarding this apparent change in policy/practice, as well as the criteria that would be used to determine the appropriateness of an individual returning to the Facility. <u>Confirmation Pre-Move Required Supports In Place</u> The Facility did not submit any reports from the Local Authority (previously Mental Retardation Authority) as assurance that pre-move supports were in place prior to an individual's transition. As noted in previous reports, the LA's review appeared to be a general safety assessment as opposed to an individualized assessment based on the pre-move supports identified by the team. As noted in previous reports, the Facility had begun to implement the process of having the Post-Move Monitor conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. A review was conducted of the pre-move site visit documentation for the nine individuals' that had transitioned since the Monitoring Team's last review (100%) (i.e., Individual #107, Individual #13, Individual #316, Individual #221, Individual #237, Individual #59, Individual #197, Individual #257, and Individual #121). The pre-move site reviews appeared to have been completed in a timely manner. Although they generally appeared thorough, and included each pre-move support listed in the individuals' CLDPs, some concerns were noted. Each report identified the evidence that had been reviewed to determine that the pre-move support was in place. Concerns were noted with regard to some of the evidence reviewed as well as the criteria	

#	Provision	Assessment of Status	Compliance
		used to determine the adequate existence of the pre-move supports. Concerns included: ▪ Particularly with regard to the training Facility staff had provided to community provider staff, the issues were two-fold. First, in some reports (e.g., Individual #121, Individual #257, Individual #197, and Individual #59), evidence was supposed to include review of copies of training materials used. In the narrative, the only reference was to sign-in sheets for the training. It was unclear whether the Post-Move Monitor also looked at the training materials to determine their comprehensiveness and adequacy. Even when training materials were referenced, no indication was given that the Post-Move Monitor evaluated the quality of the training or the materials used. Second, for some individuals (e.g., Individual #316, Individual #13, and Individual # 107), it was unclear if all of the required training related to nursing care plans was completed. The list of topics that the Post-Move Monitor documented as having been completed was different from the list in the "essential support" column. ▪ For one individual (i.e., Individual #237), it was unclear why the pre-move support related to psychiatry was considered completed. The essential support listed was: "Establish services with a psychiatrist for monitoring of psychoactive medications." The Post-Move Monitor noted that the provider staff were: "trying to get an appointment." This did not appear to equate to establishing services with a psychiatrist. Particularly given the problems with identifying adequate psychiatric services in the community, it was unclear why this was accepted as completion of the pre-move required support. As has been noted in previous reports, the process was becoming more complicated as more pre-move supports were appropriately identified in individuals' CLDPs. Based on interview with the Admissions and Placement staff, they indicated that two individuals' transitions had been delayed due pre-move required supports not being in place (i.e., Individual #221 and Individual #59). Neither of these individuals' pre-move site reviews indicated problems had been noted. However, in reviewing their CLDPs, it appeared that training was delayed for Individual #59, so his transition date was delayed one day. It also appeared the Post-Move Monitor's review of the essential supports was delayed until the day the training was completed. Although Individual #221's CLDP indicated that his transition was delayed due to "the fact that the essential supports were not in place prior to the day of the transition," no details were provided, and the pre-move site review report did not show any missing supports. It was positive that individuals did not move prior to supports being in place. These issues appeared to have been identified through ongoing communication of team members as opposed to the actual pre-move monitoring process. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress had been maintained with regard to confirmation of pre-	

#	Provision	Assessment of Status	Compliance
		move required supports, concerns were noted with the confirmation of training completion, as well as criteria used to confirm adequate supports were in place. In addition, although some progress had been made with the delineation of the pre- and post-move required supports in individuals' CLDPs, many protections, supports, and services continued to be missing.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Progress had been made and/or sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that CLDPs are developed and the Facility implements the portions of Section T of the Settlement Agreement for which it is responsible. Positive developments included: ▪ At the time of the Monitoring Team's previous review, the Facility was using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. At the time of this most recent review, the Facility continued to conduct audits using these tools. However, at the time of the review, some changes were being made to the monitoring activities for Section T. With the introduction of the Transition Specialists, they were to play a monitoring role. For example, they were expected to begin monitoring 75 percent of the post-move monitoring activities, and the Program Compliance Monitor was expected to monitor the remaining 25%. The Admissions Placement Coordinator and the Program Compliance Monitor continued to each monitor four Living Options discussions monthly. The Program Compliance Monitor continued to monitor Community Living Discharge meetings. ▪ The QA Department and staff from the Admissions Placement Department met monthly. Based on interview, the Admissions Placement Coordinator indicated they had seen some improvement with regard to living options discussions, but noted that with turnover in QDDPs, it was likely that retraining would need to occur. Areas noted in which improvements were needed included the identification of obstacles and the action plans to address them. However, a decision had been made to provide an opportunity for QDDPs to use the new ISP format for a little while. It structured the discussion about living options differently, and it was hoped this would help improve the teams' discussions and documentation of their decision-making. ▪ The Facility had continued to incorporate the data from its monitoring process into its self-assessment. ▪ 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. The Monitoring Team had asked for some basic data in this regard, and for this review, the Facility provided a summary of the data it had collected. Specifically, the Facility provided a list of individuals who had	Noncompliance

#	Provision	Assessment of Status	Compliance
		transitioned to the community indicating whether or not since their transition, they had: 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. As discussed below, the next step in this process will be analyzing this information, through thorough and critical reviews of the circumstances of such incidents/events, and determination of whether or not improvements are needed in the transition processes. Areas in which continued efforts needed to be made included: ▪ Inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. The Facility was collecting inter-rater reliability data and the QA Department and staff from the Admissions Placement Department met monthly with one goal being to attempt to resolve discrepancies in monitoring. Focus should be placed on ensuring that not only are the results of the monitoring similar, but also that they are 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. ▪ Analysis of the monitoring data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. ▪ As noted above, an important part of quality assurance for Section T will be review of the outcome data for individuals that transition to the community. Analysis should include review of supports that might have prevented negative outcomes, and a determination of whether or not such supports were included in CLDPs, as well as whether or not community providers provided the necessary supports. Based on data the Facility provided, since the Monitoring Team's last review, two individuals had had police contact, including one individual that had three instances of police contact, and a second individual that had had five instances of police contact. The first individual had called the police himself once after being aggressive towards staff, and in the other two	

#	Provision	Assessment of Status	Compliance
		instances, he had an authorized departure from his day program, and was found running in traffic. His placement at the vocational program was in jeopardy, because they only allowed three incidents before they terminated his enrolment. This individual also had an Emergency Room visit. The second individual had been arrested three times and had spent approximately 37 days in jail. At the time of the Monitoring Team's onsite review, this individual's guardian had contacted the Facility about the possibility of him returning to LBSSLC. Although the Facility was taking action to address the issues with the provider that served both of these men, it would be important to conduct a critical analysis of the CLDPs and their implementation. The teams for two other individuals found out that after they transitioned to their new home that an individual moved in who was not compatible with them, and potentially placed them at risk. At the Facility's request, the provider agency moved the two women to another home. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should continue to expand its monitoring activities for Section T, 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 should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.	
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	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. As noted in the Monitoring Team's previous report, 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 annual report. Data included the 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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 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).	

#	Provision	Assessment of Status	Compliance
		Since the Monitoring Team's last review, the Facility had continued to gather data related to obstacles. As discussed in detail with regard to Section T.1.b.1, concerns continued to exist with teams' accurate identification of obstacles. Based on review of individuals' ISPs, teams continued to struggle with understanding the potential obstacles, and selecting the appropriate ones. As a result, the validity of the data was questionable. For example, based on a review of a limited number of ISPs, it appeared that at times, teams identified individual reluctance as the obstacle, even when for example, an individual's understanding of living options could not be and likely never could be assessed. Careful planning also would be necessary to allow teams to assess an individual's preferences for community transition, when the team had difficulty assessing the individual's preference for less complex choices. Based on interview with Admissions and Placement Department staff, given that the revised ISP format included a revised section on obstacles, since the last review, additional training had not yet been provided to teams on obstacles. Based on the Monitoring Team's limited review of the new ISP process, teams continued to struggle with the appropriate and accurate identification to obstacles to referral. LBSSLC had not yet begun to systematically collect data on obstacles to transition. As discussed with regard to Section T.1.b.1, as individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. Of additional concern, when asked for "the most recent report of the Facility's analysis of major obstacles to individuals' movement to community living," the Facility provided a copy of the annual report dated 8/31/11. The same report was produced in response to a request for "a print-out of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate. Based on these responses, it was unclear whether or not the Facility was regularly reviewing and analyzing the data related to obstacles (e.g., through its QA/QI Council and/or meetings between the QA Department and the Admissions and Placement Department). As a result, it was unclear if the Facility had developed any plans or taken any action to address obstacles within its control. The Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. In developing such a report, it will be important for the Facility to incorporate staff's knowledge of issues that potentially impede transition. Actions the Facility can take locally or with which Transition Specialists can assist, as well as those that fall more into the realm of DADS State Office should be incorporated into the report.	

#	Provision	Assessment of Status	Compliance
		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 achieved.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report, for the period between 3/1/12 and 8/22/12. 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. Nine individuals were included on this list. Three of these individuals had moved since the report was produced. ▪ 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 six individuals. As noted above, three individuals had moved since the list was produced. During December 2010, the Monitoring Panel requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses. For these categories, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the names of eight individuals with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: No individuals were listed in this category. ▪ 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. LBSSLC provided a list as an attachment to the Community Placement Report. It included the names of 16 individuals who the IDT would have referred for	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		transition to the community, if not for the objection of the LAR. 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 individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for seven individuals (i.e., Individual #107, Individual #13, Individual #316, Individual #221, Individual #237, Individual #59, and Individual #197). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted 16 reviews. Of the 16 required visits, 13 (81%) had been documented as having been completed on time. For three individuals, copies of reports were not provided for reviews that should have been completed (i.e., Individual #13 and Individual #316, both of whom had moved to a different home in July 2012 after the 30/45-day review, but for whom additional reports should have been available; and the 30/45-day review for Individual #59). <u>Visits to All Sites</u> The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was clearly documented in the reports. <u>Content of Checklists</u> LBSSLC continued to use the revised format that the State Office had developed for post-move monitoring activities, which had been modified 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. Although the checklists reviewed generally were completed thoroughly, some issues were noted. To put this in context, because many additional supports were appropriately being added to the CLDPs, the post-move monitoring activities had become more complicated. Given this factor, it was positive that the reports were generally completed in a thorough manner. However, some concerns were noted with regard to ensuring and/or documenting that each pre- and post-move required support was in place in a timely manner. More specifically: ▪ As noted above with regard to Section T.1.e, some issues were noted with regard	Noncompliance

#	Provision	Assessment of Status	Compliance
		to the evaluation of training provided to community provider staff during pre-move reviews. These same issues were noted when changes in staff occurred, and training needed to be completed. ▪ In some cases, the documentation did not support the Post-Move Monitor's thorough review of the support stated in the CLDP. For example: o For Individual #237, review of implementation of nursing care plans included interview with nurse who said they were being implemented and "copies of nursing care plans." It was not clear that the quality with which the nursing care plans were being implemented was reviewed. o For Individual #221, a support was listed as: "Psychologist to follow up to review the need for behavioral program and contracts." For the 45-day visit, the Post-Move Monitor stated: "Reviewed notes from [psychologist]." It was unclear what the psychologist was doing during weekly visits, and whether or not the behavioral plan or related data had been reviewed to determine the need for changes. o For Individual #316, the PBSP was to be implemented. However, the reports did not indicate that the Post-Move Monitor had reviewed behavioral data. Rather, the Post-Move Monitor indicated that the PBSP was present, and upon interview, staff said they were implementing it. o For Individual #107, the monitoring of the continuation of the PBSP did not consistently include review of behavioral data. It appeared during the seven-day review that logs were reviewed. However, during the other reviews, it appeared that such documentation was not reviewed, but rather interviews with staff occurred. ▪ The criteria used to confirm the existence of a support did not consistently appear to be stringent enough. For example: o For Individual #237, one of the supports required communication with the LAR, including communication about physician appointments. In the narrative, the Post-Move Monitor indicated: "Staff are uncertain if he is contacted regarding doctor's appointments," but this supported was marked as present. It also was unclear if this was based solely on interview or if documentation had been reviewed. o For Individual #221, although the support was marked as having been provided, it was not clear that the following support was adequately in place: "Attend [work center] and engage in preferred work activities." In the narrative, the Post-Move Monitor appropriately expressed a number of concerns about the lack of adequate work activities being offered to Individual #221, so it was unclear why this was rated as being present.	

#	Provision	Assessment of Status	Compliance
		Use of Facility's Best Efforts to Ensure Supports Are Implemented 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 seven individuals reviewed, six of them (86%) had needs identified for follow-up to be conducted to ensure supports were implemented. The only individual for whom no follow-up activity was required was Individual #59. ▪ Although LBSSLC staff had taken a number of important steps to correct issues identified, for none of the six individuals (0%) was documentation presented to show that adequate action had been taken. Concerns included: o It is the Monitoring Team's understanding that after each review the Post-Move Monitor conducts, the IDTs are to meet to review the report and make any necessary recommendations and/or to take appropriate action. In its document request, the Monitoring Team requested: "all completed pre-move and post-move monitoring checklists… including additional documentation, if any, that reflects follow-up activity taken by the PMM, IDT, or the Facility in response to issues identified in the post-move monitoring checklists. However, no follow-up documentation from IDTs was included. It remained unclear if the required meetings were taking place, and, if so, what involvement IDTs had in addressing concerns the Post-Move Monitor identified. o When serious issues were identified with a community provider supporting a number of individuals that recently had transitioned (including Individual #221 and Individual #237), a number of Facility staff had become involved in attempting to correct the issues. This included the Post-Move Monitor, the Admissions and Placement Coordinator, the Assistant Director of Programs, and the Facility Director. Strong action was taken, including contacting the Executive Director for the provider's state office. This was commendable. At the time of the Monitoring Team's review, it remained unclear whether or not the underlying issues had been fully resolved. Of concern, the significant issues identified impacted the individuals recently transitioned, but potentially also individuals for whom the 90-day monitoring already had occurred. The issues with the provider appeared to be systemic within the homes the provider operated in the Lubbock area. However, it did not appear from the documentation provided that the Local Authority staff had been asked to intervene or oversee corrections that needed to be made. Similarly, it remained unclear to the Monitoring Team if the regulatory agency should have played a role. Both of these are options the Settlement Agreement	

#	Provision	Assessment of Status	Compliance
		contemplated. o Although post-move monitoring follow-up activities were identified in some detail in the narrative sections, the charts at the end of the reports provided minimal information, and essentially repeated the same action step: "Follow up and review documentation at the 30/45 and/or 90 day monitoring." Generally, this did not set forth an adequate action plan. A different designation should be used for supports that are not yet due. Action plans should be developed primarily for supports that are overdue or adequate action has not been taken to ensure they are completed when they are due. Although progress continued to be made with regard to the post-move monitoring process, as the CLDPs continue to include more detailed protections, services, and supports, care will need to be taken to ensure that monitoring adequately confirms the existence of the supports. In addition, follow-up to the monitoring visits remained a challenge for the Facility, particularly with regard to the involvement of IDTs in the process. The Facility remained out of compliance 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		

#	Provision	Assessment of Status	Compliance
	criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (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	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 without formal transition planning occurring, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge procedures. Since the last review, one individual had transferred to another SSLC (i.e., Individual #302). This was the only individual that met the definition of an alternate discharge. Based on a review of the discharge summary completed for Individual #302, each of the requirements of the CMS-required discharge planning process is discussed below: ▪ **If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause:** Based on the information provided, in one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., the family's desire to have the individual live closer to them to increase family contact). ▪ **The Facility provided a reasonable time to prepare the individual and her parents or guardian for the transfer or discharge (except in emergencies):** It appeared the individual's brother had been discussing this with the Admissions Placement Coordinator and QDDP over time. The brother was not Individual #302's guardian. The discharge summary indicated: "[Individual #302] refused to attend the Transfer Discharge Meeting. His IDT members have discussed the upcoming transfer with [Individual #302]. Officially, he has been made aware of the upcoming transfer via letter from the Admissions Placement Coordinator, dated 2/27/12. In this letter [Individual #302] was given his 31 day notice of the proposed transfer and informed of his right to an	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	order.	administrative hearing should he choose to contest the transfer." Although not explained in the discharge summary, given that Individual #302 had difficulty with communication, it likely was difficult for his team to determine whether he understood and/or agreed with the discharge. However, it appeared the Facility had made efforts to inform the individual of the pending transfer, and that his family was in favor of the move. ▪ **At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status:** The final summary included each of these components for one of one individual (100%). Fairly specific and extensive information was provided for each. However, it should be noted that these summaries appeared to be a verbatim reiteration of the assessment information. A summary that particularly focused on the individual's current status, including data, where applicable, as well as, as applicable, historical highlights of the individual's over 40 year stay at LBSSLC would have been more helpful. ▪ **With the consent of the individual, parents (if the individual is a minor) or legal guardian, provides a copy to authorized persons and agencies:** For one out of one individual (100%), the discharge summary indicated a copy of it and the related assessments would be transferred to the receiving SSLC, as well as the family, and LA. It also indicated a copy of his full records had been sent previously to the receiving SSLC. ▪ **The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment:** Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDTs for one of the one individual (100%) adequately described the key supports that the individual would need in his new settings. For Individual #302, the discussion included specific supports, and also referenced some important preferences to make the transition easier. Because past experience showed Individual #302 did not like changes to his environment, to ease the transition, the team identified the staff that would accompany him, and training that the psychologist would do. This was presented in a narrative, as opposed to action plan format, but appeared to be sufficient to meet the minimal standards included in the CMS guidelines. As appeared to be the intent of this subsection of the Settlement Agreement, the same standards for an adequate plan found in other subsections of Section T were not applied here. As a result, the Facility was found in substantial compliance with this provision.	

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

1. The professional teams supporting individuals at LBSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. (Section T.1.a and T.1.b.3)
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 demonstrate competence in the identification of obstacles to referral as well as obstacles to transition of individuals to the most integrated setting appropriate to their needs and preferences. (Section T.1.b.1)
4. Obstacles 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)
5. 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)
6. 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)
7. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as teams' plans to overcome them. (Section T.1.b.1)
8. Teams should demonstrate competence in the development of action plans/strategies to overcome identified barriers. (Section T.1.b.1)
9. LBSSLC should expand the creative and individualized educational activities to meet the needs of various individuals and families/guardians. (Section T.1.b.2)
10. 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 and Transition Specialists should play a key role in working with teams to individualize these action plans. (Section T.1.b.2)
11. 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)
12. Pre-move and post-move required 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 is 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., a

pre-move required 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. As the Monitoring Team has recommended previously, 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 should be built. As ISPs improve, it is essential that teams use the supports in the ISP as a basis for the development of the CLDP;

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 pre-move and post-move required supports;

h. As appropriate, teams should identify as a pre-move or post-move required 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 pre-move and/or post-move required 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 a pre-move or post-

move required 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;
p. Focused effort should be placed on ensuring each of the supports identified is measurable; and
q. As appropriate, programs on which individuals are working at the Facility to increase their independence should be considered for formal implementation in the community. (Sections T.1.c.1 and T.1.e)

13. 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)
14. 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)
15. The "evidence" identified in CLDPs to confirm the provision of protections, supports, and services should be improved. In addition to showing a clear linkage with the actual implementation of the protection, service, or support, consideration should be given to various methods for monitoring, including observations, document review, and staff interview. (Section T.1.e)
16. 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)

17. As has been recommended in previous reports, the State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., are transferred to a mental health hospital after transitioning to the community), whose community transitions are in jeopardy, or who experience other significant negative outcomes (e.g., police contact, arrest, unexpected hospitalizations, unauthorized departures, etc.). (Section T.1.f)
18. Whenever appropriate, IDTs should identify actions necessary to resolve issues related to the pre-move and post-move required 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: ▪ **Review of Following Documents**: o Draft LBSSLC Guardianship Process policy, revised 8/7/12; o Prioritized List of Those in Need of and Legally Authorized Representative (LAR), revised 8/8/12; o Prioritized List of Those in Need of and Legally Authorized Representative (LAR), revised 9/27/12; o New Guardians, revised 9/27/12; o Contact Log regarding guardianship from 3/29/12 through 8/19/12; o Agenda for Guardianship: Perfecting the Process, dated 6/15/12; o Handouts, and certificate of attendance for Human Rights Officer for A Closer Look at Adult Guardianship, dated 8/30/12; o Statement that: "No Minutes taken between QA/QI and Shelia Powell;" o Presentation Book for Section U; o Self-Assessment for Section U, updated 9/27/12; o Provision Action Information, undated; o Action Plans: Section U, updated 9/17/12; o Blank monitoring form for Section U: Settlement Agreement Cross Referenced with ICF/MR Standards – Section U, dated, 12/10; 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; and 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. ▪ **Interviews with**: o Shelia Powell, Human Rights Officer/Guardianship Coordinator; and o Autumn Warfel, Assistant to Human Rights Officer.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U, dated 9/27/12. In its Self-Assessment, for each sub-section, 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. For Section U, in conducting its self-assessment:

	▪ Although based on interview and document review, the Facility was using a monitoring tool for Section U, in its Facility Self-Assessment, the "results" sections included no evidence of use of the data collected on these tools. For example, no sample sizes were provided, or results from review of individuals' records. Based on interview with the Guardianship Coordinator, she had had discussions with the QDDP Coordinator about the possibility of revising the current ISP monitoring tool to include more information related to consent and guardianship. ▪ The Facility used other relevant data sources. For example, the Self-Assessment included numbers of individuals requiring guardians, as well as those that had obtained guardians. However, it should be noted that these numbers were not consistent with those provided in other documents (i.e., 83 individuals requiring guardians versus 80 individuals on the prioritized list of the same date). ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section U. This was consistent with the Monitoring Team's findings. ▪ The Facility Self-Assessment identified areas of need/improvement. For these areas of need, the Facility Self-Assessment did not provide an analysis of the information, or connect 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. 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. In addition to providing statistics and narrative descriptions of activities, the self-assessment should include analyses of the audit results.
	Summary of Monitor's Assessment: At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. LBSSLC was in the process of finalizing the local policy on guardianship, which essentially adopted the State Office policy with some minimal changes. Because the process that LBSSLC had used previously for individuals' teams to determine priority levels for guardianship largely mirrored the State Office policy, the Facility had not needed to redo this process. However, other aspects of the policy's implementation remained in the planning phase, such as the development of a Guardianship Committee, which ultimately would be the entity responsible for deciding upon the prioritization of the overall list of individuals requiring guardians. As a threshold issue, prioritizing an individual's need for guardianship cannot be done adequately until a process is in place to screen for an individual's need for a guardian. At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using an adequate standardized tool. However, it was anticipated that the State Office policy 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. LBSSLC had begun to complete some research on assessment used in other states as well as current

	assessments that teams could utilize in this process. Although it was positive that Facility staff were taking initiative, due to the complexity of this type of assessment, these efforts should be done in conjunction with State Office and other Facilities. The updated prioritized list, dated 9/27/12, included names of 80 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 38% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 37 individuals had a Priority I need for guardianship, 36 individuals were in the Priority II category, and seven were in the Priority III category. LBSSLC had continued to work mostly with the families of 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 four individuals in some phase of the process. However, since the last review, limited efforts had been made, such as working with State Office, to identify other potential guardianship resources. The Facility also was in the initial stages of re-developing a Guardianship Committee. This would be an important initiative, because, such a group, if properly constituted, might be helpful in identifying resources related to alternatives to guardianship, potential guardians, as well as funding to support individuals for whom the guardianship fees prohibit them from applying to become a guardian. One barrier to families becoming guardians on which the Facility continued to work was the funding needed to petition the court for guardianship. Facility staff had continued to work with the Family Association, which now had a subcommittee to review applications for funding for guardianship proceedings. In addition, the Guardianship Coordinator had worked with the Assistant Director of Administration on "waiver of board and care" to allow payment of guardianship costs.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to	At the time of the Monitoring Team's previous review, DADS State Office just recently had issued Policy #019: Guardianship, dated 3/7/12. Since the last review, the Facility had drafted a corresponding Facility policy. On 9/25/12, the draft had been approved with some revisions, and at the time of the Monitoring Team's onsite review, it was being finalized. The next step was training IDT members on the new policy. In addition, according to the Guardianship Coordinator, steps also would be taken to re-establish a Guardianship Committee. Based on the draft Facility policy and consistent with State Office policy, the Guardianship Committee would be responsible for "developing, prioritizing and maintaining a list of individuals who: Do not have the functional capacity to make decisions regarding their own health or welfare; and do no have an existing LAR to make such a decision." The Guardianship Coordinator had begun to make contacts regarding potential candidates for the committee.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	A second DADS policy on consent remained in the development phase. It reportedly would address the assessment of individuals' functional capacity. Since the last review, because LBSSLC was awaiting further guidance through State Office policy, it had continued its efforts to develop a prioritized list of individuals requiring guardians, and to identify guardians and pursue guardianship for individuals. However, as discussed while the Monitoring Team was on site, an important first step was missing. Specifically, the Facility continued to use the Rights Assessment to determine individuals' ability to make informed decisions. This tool with its related instructions was inadequate to determine an individual's functional capacity to make decisions. The Facility had begun to conduct some research on how other states were completing assessments of functional capacity, and reviewing assessments IDTs already were conducting to determine their potential role in assessing functional capacity. Given the complexity of such an assessment, the Facility should coordinate its efforts. 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 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 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 discussed in the Monitoring Team's previous reports, 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 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. Because these activities were consistent with the requirements in DADS Policy #019, the Facility did not redo the process.	

#	Provision	Assessment of Status	Compliance
		Based on interview with the Guardianship Coordinator, at times, when changes in status or risk factors came to her attention, she requested to meet with individuals' teams to review their priority need for guardianship. For example, as the Human Rights Officer, she had access to documentation and participated in meetings at which risk factors and/or changes in status were discussed. Some of these activities included participation on the Ethics Committee, the Human Rights Committee, the Dental and Medical Desensitization Committee, and the Incident Management Review Team. Reportedly, as appropriate, changes were made to the prioritized list. The updated prioritized list, dated 9/27/12, included names of 80 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 38% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 37 individuals had a Priority I need for guardianship, 36 individuals were in the Priority II category, and seven were in the Priority III category. Based on information the Facility provided, in the last report, the Monitoring Team indicated that 92 individuals were on the prioritized list. Since then eight individuals had obtained guardians. However, without going through the log of individual or team contacts, it was unclear what had happened to the remaining four and/or if additional individuals had been added to or subtracted from the list. Moving forward, the Facility should indicate on the prioritized list which individuals have been removed, the date removed, and the reason, as well as the date any individuals were added and/or their priority levels modified. 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 had made some progress in developing a local policy on Guardianship.	

#	Provision	Assessment of Status	Compliance
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 Monitoring Team's previous visit, eight individuals had guardians appointed. The Facility also provided a list of new guardians since October 2007. Although some of the information pre-dated the Settlement Agreement, it appeared that since monitoring of the Settlement Agreement began, 23 individuals had obtained new 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 four individuals, and guardianship information packets had been sent to an additional eight interested parties. As noted above, the list the Facility provided showed that a total of 80 individuals of the 211 individuals served by the Facility (38%) 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 in the Monitoring Team's last report, the Facility had worked 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. Since that time, an application form had been finalized, and a subcommittee of the Family Association was set up to review and approve applications. This option appeared to be a valuable one for some of the families interested in pursuing guardianship. In addition, the Guardianship Coordinator had worked with the Assistant Director of Administration on "waiver of board and care" to allow payment of guardianship costs. It was the Guardianship Coordinator's understanding that this was the same as the "applied income" option that other Facilities had identified. Although it had not been used yet at LBSSLC, it was positive that this in conjunction with the Family Association's fund would help defray the costs of petitioning for guardianship. Although it was positive that the Facility continued to work with individuals' families and other people involved in their lives, limited action had been taken to expand the possible outlets for identifying guardians for individuals. For example, during one of the Monitoring Team's onsite reviews, State Office staff had offered to work with LBSSLC staff on identifying nonprofit agencies in the area and discussing grant opportunities	Noncompliance

#	Provision	Assessment of Status	Compliance
		with them to develop guardianship programs. This had not yet been pursued. As noted with regard to Section U.1, LBSSLC had not yet implemented the portion of the State Office Guardianship policy that required development and operation of a Guardianship Committee. This would be an important initiative, because, such a group, if properly constituted, might be helpful in identifying resources related to alternatives to guardianship, potential guardians, as well as funding to support individuals for whom the guardianship fees prohibit them from applying to become a guardian. As discussed in previous reports, the Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, 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. Once the State policy on consent is finalized, LBSSLC should modify its policy on guardianship to reflect the State policy. (Section U.1)
4. Once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility. (Section U.1)
5. Based on any additional information 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)
6. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)
7. The Facility should indicate on the prioritized list which individuals have been removed, the date removed, and the reason, as well as the date any individuals were added and/or their priority levels modified. (Section U.1)
8. LBSSLC staff should collaborate with staff from DADS State Office and 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 Facility Self-Assessment should include analyses of the audit results. (Facility Self-Assessment)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS policy #020 entitled "Recordkeeping", dated 3/5/10; o Notation that there had been not revisions to the following: ▪ LBSSLC Communication Process: Recordkeeping, revised 8/9/10; ▪ LBSSLC Communication Processes: Active Record Check Out/Check In Process, dated 6/10/11; and ▪ 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 Active Record Order and Guidelines, revised 5/13/11; o Minimum Documents Included in Master Records, dated 5/16/12; o Individual Notebook and Guidelines, revised 5/13/11; o LBSSLC Review Processes: Quality Assurance Process/Plan, revised 8/30/12; o Quality Assurance checklists for last 10 records reviewed, various dates; o In response to request for plan of correction resulting from record audits, an email from the Unified Records Coordinator to All Supervisory Staff, dated 5/14/12; o Documentation showing efforts to address the plan of correction, including items such as follow-up emails and rosters for staff training, various dates; o List of new or revised Facility procedures since 2/15/12; o List of SSLC Policies, dated 9/12/12; o Emails related to training on policies, various dates; o Minutes from the Operating Procedures Manual (OPM) Review Committee, dated 5/8/12, 6/12/12, 7/3/12, 7/10/12, 7/31/12, 8/28/12, 9/4/12, 9/11/12, and 9/25/12; o As provided, the following documents: a) curriculum used for training; b) any competency-based test or checklist; c) sign-in sheets; and d) identification of number and/or names and positions of staff that have not yet completed training, for the following policies: 1) Individual-to-Individual Aggression; 2) Mealtime Procedure; 3) Controlled Medications; 4) Injections; and 5) Limitation of Restraint; o Communication regarding policies changes, including emails with various dates; and o Presentation Book for Section V. ▪ **Interviews with**: o Javier Vasquez, Unified Records Coordinator; and o Dawn Ripley, Director of Quality Assurance.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 9/17/12. In its Self-Assessment, for each sub-section, 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.

	For Section V, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 review tool with guidelines; Settlement Agreement Provision 4 – Interview Tool for Use of the Record with guidelines; Record Guidelines Monitoring with guidelines; review of check-in/check-out sheets; and review of sample of Submission and Filing Tracking Sheets. o The Facility was continuing to work to modify the indicators on the monitoring tools to ensure that they were adequate to address the various provisions in Section V. A good example of modification to monitoring indicators to ensure the information collected was valuable occurred with regard to Section V.1. In its Self-Assessment, the Facility indicated that when conducting reviews of the check-in and check-out documentation for records, it was determined the data needed to be broken down further to show different rates from checking the records out and then checking them back in. By doing this, the Facility realized checking records out was not a problem, but checking them in was. This then allowed the Facility to target its corrective actions to the real issue. The Facility also had added an indicator to collect information about teams' use of information in the records during meetings to address requirements of Section V.4. o The monitoring tools did not yet include adequate methodologies. Although as note above work was being done to improve them, the Facility recognized that more work was needed to obtain more information about the quality of the records (e.g., skill acquisition and behavioral data). o The Self-Assessment identified the sample(s) sizes. However, it did not consistently include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. It will be important as criteria for monitoring are developed and methodologies finalized that these be memorialized in the form of formal instructions/guidelines. o The following staff/positions were responsible for completing the audit tools: the Unified Records Coordinator and Lead File Clerk. However, the Facility was considering having just the Unified Records Coordinator conduct the reviews. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had varying levels of experience with records management, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o The staff involved in conducting the audits were actively working to improve inter-rater reliability. ▪ The Facility used to a limited extent other relevant data sources. For example, with regard to

	Section V.2, the Facility reported the numbers of new or revised policies issued. The Facility also recognized the need to track training of staff on new or revised policies. This would be an area where key indicators/outcome measures could be developed to measure compliance. ▪ The Facility rated itself as being in substantial compliance with none of the subsections of Section V. This was consistent with the Monitoring Team's findings. ▪ In the Facility Self-Assessment, some areas in need of improvement were identified. Generally, the Facility identified or referenced action plans it had put in place or planned to develop to address the negative findings. This was positive and is discussed in further detail with regard to Section V.3.
	Summary of Monitor's Assessment: Since the last review, the Facility had continued to make process in relation to recordkeeping. For example, according to staff, the Master Records had all been reorganized. The Unified Records Coordinator continued to provide training on recordkeeping at New Employee Orientation (NEO). Based on the Monitoring Team's interactions with various departments, some concerns were noted with regard to the detail required on the Submission and Filing Tracking Sheets. Reportedly, this delayed the submission of important documents for filing. As was discussed with staff on site, it will be important to obtain feedback from various departments to determine any issues and develop reasonable solutions. Since the last review, 43 procedures were developed or revised. The OPM Committee had reviewed and approved with revisions 41 of them. An additional one was pending review and approval. Review and revision of this number of policies was a significant accomplishment. The OPM had been made responsible for identifying staff that required training on policies, the timeline for completion of the training, the type of training required, the type of evidence required to reflect the completion of training, staff to whom the evidence needed to be returned, and the need for competency checks of staff knowledge following the training. Although information was being collected with regard to training on the policies, a structure was needed to make identification of staff that had not yet completed training a more efficient process. 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. Due to the systemic nature of some of the problems identified, the Facility had decided to retrain all staff on the Recordkeeping policy. At the time of the Monitoring Team's review, this training just had been completed. The Facility recognized that the next step would be aggregating and analyzing information gained through record audits in more depth to determine if more specific corrective action was needed. Using monitoring data, the Facility also had developed a plan to address issues related to checking records back in when they were returned to the residences. It was positive that the Facility was using data in this way. Based on observations of team meetings, teams were more consistently using data, and other information

	contained within individuals' records, to make care, treatment, and training decisions. However, improvements in this regard were still necessary. 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.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As noted in previous reports, a review of the LBSSLC policy on recordkeeping, revised in 8/9/10, revealed that it was consistent with the DADS policy on record keeping, and Appendix D of the Settlement Agreement. Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. ▪ At the time of the last review, the 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. Since then, staff reported that all of the records had been reorganized. Based on a change State Office made, a new tab was added to all the Master Records for agreements between the Protection and Advocacy Agency and individuals whom they represented. ▪ 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. ▪ Since the last review, the Facility had maintained its secure bins for protected health information, as well as its processes for the collection and destruction of such documents. Larger bins had been purchased for areas with bigger volumes of documents. ▪ The Unified Records Coordinator and Medical Records Clerk attended a course entitled HIPAA [Health Insurance Portability and Accountability Act] Compliance after the HITECH [Health Information Technology for Economic and Clinical Health] Act. This should assist the Facility, particularly as more electronic records are used. ▪ Since March 2012, the Unified Records Coordinator had continued to provide an hour-long training session as part of New Employee Orientation. Based on the course outline and the PowerPoint presentation, it appeared to be comprehensive, but easy-to-understand training. It included a written test. ▪ LBSSLC continued to implement its policy entitled: LBSSLC Communication Process: Process for Submission and Timely Filing of Information in the Active	Noncompliance

#	Provision	Assessment of Status	Compliance
		Record, dated 8/11/11. The Facility had begun to review the Submission and Filing Tracking Sheets to determine a percentage of sheets that showed that all documents on the sheet had been filed timely. This data was included in the Facility Self-Assessment, and showed high compliance. As Facility staff noted, this data could be used to determine if particular file clerks were having issues, needed additional assistance, etc. Areas in which improvements should be made in order to achieve compliance, included: ▪ As Monitoring Team members interacted with staff and reviewed records, a concern related to the Submission and Filing Tracking Sheets was raised. Specifically, the time it took to complete the forms was raised as a challenge, particularly for departments with many documents requiring submission. Reportedly, at times, this delayed the submission of important documents for filing. As was discussed with staff on site, it will be important to obtain feedback from various departments to determine any issues and develop reasonable solutions (e.g., dropdown menus or other methods to reduce time spent entering information, grouping similar documents, etc.). Given the importance of this process in ensuring timely filing and increased accountability, ensuring it is as practical and workable as possible is essential to making sure it continues to be used consistently and that documents are both submitted and filed timely. ▪ 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, given the systemic nature of the problems, the decision was made to require all staff to be retrained on the Recordkeeping policy, as well as the monitoring tool the Facility used to review records. At the time of the Monitoring Team's review, the training just recently had been completed. As a result, it was too early to tell the result. Facility staff indicated that further action would be taken based on the results of ongoing monitoring. ▪ 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	

#	Provision	Assessment of Status	Compliance
		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. Based on its own monitoring, the Facility had identified concerns with staff signing in records when they were returned to the residences. It was positive that the Facility had found this problem on its own. Records Department staff reported plans to meet in the weeks following the Monitoring Team's review with residential staff responsible for oversight of this process. The plan was to have Home Team Leaders check for the presence of records at the end of each day and contact the Unified Records Coordinator if any records were missing. 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.	
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, 43 procedures were developed or revised since the previous compliance review. The OPM Committee had reviewed and approved with revisions 41 of them. An additional one was pending review and approval. Review and revision of this number of policies was a significant accomplishment, and had required the OPM Committee to meet twice monthly. ▪ The OPM had been made responsible for identifying staff that required training on policies, the timeline for completion of the training, the type of training required, the type of evidence required to reflect the completion of training, staff to whom the evidence needed to be returned, and the need for competency checks of staff knowledge following the training. The minutes of recent meetings showed that the group was having these discussions, and the minutes	Noncompliance

#	Provision	Assessment of Status	Compliance
		documented the decisions the group made. ▪ Based on a review of the correspondence sent regarding new or revised policies, since the initiation of the new process for defining training, the emails included the necessary information (e.g., who needed to be trained, timeline, type of training, etc.). The Facility also provided examples of reminder emails when required training had not been completed. 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. ▪ The Monitoring Team requested the following documents: a) curriculum used for training; b) any competency-based test or checklist; c) sign-in sheets; and d) identification of number and/or names and positions of staff that have not yet completed training, for the following policies: 1) Individual-to-Individual Aggression; 2) Mealtime Procedure; 3) Controlled Medications; 4) Injections; and 5) Limitation of Restraint. For all of the policies, the Facility submitted sign-in sheets. For only the Limitation of Restraint policy, in addition to some sign-in sheets, the Facility submitted a printout from the State's system to track training. For none of the policies, the Facility identified the number or names/positions of staff that had not yet completed the training. It remained unclear to the Monitoring Team what system the Facility had in place, if any, to track this information and be able to follow-up to ensure that staff that had not completed the training eventually completed it. Given the numerous sign-in sheets for each training, and the many notations regarding staff being on leave, staff no longer working for the Facility, etc., a structured system would be necessary to track attendance at training, as well as successful completion of any required competency checks. 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 tracking 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	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ Based on documentation submitted, it appeared the Lead File Clerk was completing five record audits per month. The Unified Records Coordinator subsequently completed a review of the same five records. At the time of the	Noncompliance

#	Provision	Assessment of Status	Compliance
	procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	review, the Facility was considering having only the Unified Records Coordinator conduct audits. As discussed while the Monitoring Team was on site, this provision of the Settlement Agreement requires only five record reviews. The Facility is encouraged to ensure that a back-up process is in place and that inter-rater reliability is established and maintained between anyone responsible for record reviews. ▪ As previously reported, beginning on 1/1/11, LBSSLC began using the monitoring review tool the State Office developed entitled Recordkeeping and General Plan Implementation for Sections V.1, V.3, and V.4. The Facility continued to use its own review tool for monitoring records, and the results were reflected on the State Office tool. Based on the data from these reviews, the Facility had identified for systemic action to correct repeated deficiencies. On 5/24/12, the Unified Records Coordinator sent an email to all supervisory staff requesting retraining of all staff on the record keeping process and monitoring tool. After follow-up emails in June and July 2012, Facility staff reported that all departments had submitted training documentation. Although training documentation was submitted, the Monitoring Team could not determine if all staff had been trained. ▪ In addition, starting in June 2011, one individual's team was selected for completion of the State Office's interview tool designed to solicit information specifically about Section V.4, which requires the Facility to routinely utilize individuals' records in making care, medical treatment, and training decisions. ▪ The Facility also had determined that some additional monitoring was necessary. This included: o The Unified Records Coordinator was completing a review of the check-in/check-out sheets for records. Based on this monitoring, the Facility had determined the need to improve the check-in process when records were returned to the residences. o The Lead File Clerk conducted monitoring of Submission and Filing Tracking Sheets. She reviewed all sheets. If one document on a page was filed late, then the sheet was counted as "late." Based on the Facility Self-Assessment, the data showed a 91% timeliness rate. o The Unified Records Coordinator had begun to attend a sample of ISP meetings. The records of the individuals were then reviewed after sufficient time for the new ISP to be completed, as well as documents such as skill acquisition plans. This was a good practice, because it provided the Unified Records Coordinator with more information to make sure the record was complete. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, the Facility was using some data to determine issues that	

#	Provision	Assessment of Status	Compliance
		required correction. At the time of the Monitoring Team's review, some of the corrective actions had just been completed (e.g., retraining all staff on Recordkeeping policy) or in the process of being addressed (e.g., meeting scheduled to address the issue related to checking in records). It was too early to tell whether the completed or planned actions were effective. ▪ The Facility recognized that the next step in the process was reviewing aggregate data to identify unresolved issues, analyzing the data in more depth to identify specific issues or departments requiring more attention, and developing corrective actions, as appropriate, to address them. The QA Director indicated that she and the QA Nurses were scheduled to attend training at State Office related to the analysis of data. ▪ Efforts to establish inter-rater reliability between the Unified Records Coordinator and the Lead File Clerk had continued. As noted above, the Facility was considering removing the monitoring responsibility from the Lead File Clerk. Even if this were to occur, there remained a need to ensure that the data the Unified Records Coordinator was collecting data that was both valid and reliable. ▪ At the time of the Monitoring Team's previous review, the Facility had begun a process to follow-up on issues identified through individual record reviews. Consistent implementation of this process will need to be a part of the overall quality assurance system for records. Although progress continued to be made with regard to this provision of the Settlement Agreement, LBSSLC was still in the process of looking more formally at aggregated results of monitoring data, and developing, and implementing actions necessary to correct deficiencies identified systemically.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	Since before the Monitoring Team's last review, 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. The Facility had not yet incorporated all of the following into its monitoring. The following represent the Monitoring Team's findings with notations of where the Facility was conducting some level of review: ▪ **Records are accessible to staff, clinicians, and others**: Although LBSSLC was not yet self-assessing this, the Monitoring Team observed that: o The Facility had recognized issues with regard to both the timeliness and quality of documents. A workgroup had developed a plan to address these issues. Based on the Facility's Self-Assessment, the QDDP Coordinator and ISP Technician were tracking report submission, and once data was collected, it would be more fully analyzed. o On a positive note, in an effort to ensure accessibility of certain	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 previous couple of reports, 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. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. o From a limited review of records while on site, it was noted that a number of the Comprehensive Nursing Assessments were missing from the active records. 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. ▪ **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**	

#	Provision	Assessment of Status	Compliance
		record is used as per this provision item: In May 2012, LBSSLC just recently had added a component to the Section V Recordkeeping monitoring tool to include observation of meetings, such as ISP meetings to determine if "team members routinely use the record to make care, medical, treatment, and training decisions…" This addition was a positive one. Based on the Monitoring Team's observations: o At ISP meetings during the week of the Monitoring Team's review, the records were available and often teams referenced them when they required more details. o However, although improvement was noted, as discussed with regard to Section F of the Settlement Agreement, ISPs continued to lack evidence of teams making data-based decisions. For example, although improvements were seen with data included in the IRRFs, some data was still missing. Data frequently was not discussed with regard to other aspects of care, such as PBSPs or skill acquisition programs. 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. With regard to the Submission and Filing Tracking Sheets, Records Department staff should obtain feedback from various departments to determine any issues impacting the timely submission of documents and develop reasonable solutions. (Section V.1)
3. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures. (Section V.2)
4. The Facility should develop a standardized system to track staff's completion of training on new and revised policies, and to take follow-up action as needed. (Section V.2)
5. Monitoring efforts for Section V.4 should be further 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)
6. Development of adequate instructions for the audit tools would facilitate validity and reliability of the data collected. (Section V.3 and Facility Self-Assessment)
7. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records. (Section V.4)

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
AHRQ	Agency for Healthcare Research and Quality
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
PSI	Preferences and Strengths Inventory
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 Stimulator
VOCA	Voice Output Communication Aide
VPA	Valproic acid
VTE	Venous Thromboembolism
WBC	White Blood Count
WNL	Within Normal Limits