United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

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I. Background

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

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

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

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

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

II. Methodology

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

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

III. Organization of Report

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

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

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

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

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

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

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

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

IV. Substantial Compliance Ratings and Progress

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

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

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

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

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

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

V. Executive Summary

As this report shows, both in the additional substantial compliance findings as well as in the notable progress that should lead the Facility towards more substantial compliance findings during upcoming reviews, the Lubbock State Supported Living Center team has some strong plans in place to make change and has worked diligently to implement these plans. Some of the qualities that are most notable at Lubbock are the strong leadership and the commitment to working as a team. Based on the Monitoring Team's interactions with Facility staff, in addition to working well together, they also challenge one another. That is an important, if not always comfortable, part of teamwork. The

Monitoring Team attributes the Facility's progress to the consistently methodical approach used to prioritize areas needing improvement and tackle each of them in a thoughtful manner. Facility staff often were able to identify the areas in which more work was needed to address ongoing challenges. Continuing to creatively and systematically address these issues should bring the Facility the rest of the way.

As always, the Monitoring Team extends its sincere thanks for Facility staff's positive attitude about the monitoring visits, and all of the hard work that staff have committed to continuing to improve the quality of protections, supports, and services offered to individuals that live at LBSSLC. The Monitoring Team knows that its reviews are an added responsibility to already very busy jobs, so the Monitoring Team thanks the Lubbock team for all of its efforts to provide the needed documents, meet with the team, and address our logistical needs.

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

Restraints

- Progress was noted in a number of areas in relation to the use of restraint. Highlights of progress included:
  - The self-assessment based its determinations on data and pointed out issues.
  - The Facility had a process for updating and posting the Do Not Restrain list.
  - Trend reports tracked restraints over time and over a variety of factors, providing useful information. These reports could be used to identify both systemic and individual issues in need, or corrective action.
  - Performance indicators had been selected and while they had not been completely developed or implemented, this was a good start.
- Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with all of Section C of the Settlement Agreement included the need to:
  - Work to produce consistent and timely reviews by interdisciplinary teams (IDTs) of restraints that occur more than three times in a 30-day period or that are requested in response to data collected in the restraint review process.
  - Work with nursing on the timeliness and quality of nursing assessments of people who have been restrained.
  - Continue to mine the data for issues that may respond to a corrective action plan approach to solution.

Abuse, Neglect and Incident Management

- During this review, the Monitoring Team found the Facility to be in compliance with 20 out of 22 provisions of Section D, as opposed to 13 provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included:

- The Executive Safety Committee demonstrated the process and the potential of a key component of a sustainable system, that is, a process for examining data for trends. This process should net more of the needed actions and action plans as the Facility progresses.
- Brochures and information about reporting abuse were being provided to Legally Authorized Representatives (LARs) and individuals in annual meetings, and documented in the Individual Support Plans (ISPs) reviewed and in the meetings the team attended.
- The process for auditing injuries looked promising. While the system was new, and a full semi-annual audit had not yet been completed using the new process, there was decided progress.

- Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with the Settlement Agreement included the need to:
  - Document responses to system issues and complex individual issues that are identified through data analysis. This can be done in several ways:
    - Use the CAP system to formulate responses, particularly when multiple disciplines are needed to resolve the issue;
    - Formulate action plans where one discipline is involved in a systemic issue;
    - Use Individual Support Plan Addenda (ISPAs) to address individual issues that are identified through data analysis and link the resolution of such issues to the minutes of Executive Safety Committee or QAQI Council minutes.
  - Conduct the injury audit process to assure that the Facility identifies clusters of injuries or patterns of injuries that need investigation; and
  - Ensure Department of Family and Protective Services (DFPS) investigations include applicable recommendations. At the time of the most recent review, the Unusual Incident Report (UIR) did include them, but the long-term integrity of the process relies on DFPS to be making recommendations or registering concerns.

<u>Quality Assurance</u>

- Since the Monitoring Team's last visit, the Facility had made progress with regard to Section E, including:
  - The Executive Safety Committee was producing and reviewing data on incidents, injuries, and restraints, and trending and analyzing the data over time. The committee employed a variety of trending techniques, including graphing incidents, injuries, and restraints together to examine any correlations. Examinations of data by the Committee were thorough and productive, netting ideas on both changes to data displays, and on what data was most important to determining actions and setting priorities. This kind of attention to data analysis was a significant and positive step forward.
  - Considerable work had been done to develop key indicators of performance (labeled "Performance Indicators"). A list had been produced, grouped by Settlement Agreement Section, with input from section leaders that included the definition of the indicator, the responsible staff, the database for data

entry, the target, the baseline, the current status, and the measurable outcome. In June 2013, the use of the Performance Indicators began with Section D. Although as discussed in further detail below, more work was needed with regard to the key indicator system, this work represented a giant step forward.
    - A PowerPoint presentation, Basic Data Analysis, had been developed by the Incident Management Coordinator, approved by the Quality Assurance/Quality Improvement (QAQI) Council, and distributed to Department Heads. The presentation, based on work by an external consultant group's Protection from Harm Regional Training, was designed to highlight some key elements of data analysis in a manner that should prove useful to managers of services.
    - Department heads had been provided with a revised quarterly review format for use in developing presentations to the QAQI Council. The format included the status of corrective action plans (CAPs) and information on barriers, need for modifications, and other information to assure accurate tracking.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
    - Key indicators: to review and refine the performance measures to reflect the priorities of the Facility, to increase the indicators that describe outcomes for the population served (how their lives will be improved), not just the output of various management activities (how well staff are performing their duties).
    - CAPs development: to encourage the development of CAPs that result from data reviews and trend analyses. This necessary step toward compliance will demonstrate that the Facility can use data to inform plans for improvements in peoples' lives.
    - Data Inventory: complete a data inventory that pulls together in one place information on the databases that are used to produce reports, making sure that all data collected in the quality assurance (QA) monitoring process as documented in the QA matrix, appears in the data inventory.
    - Data analysis: Work on providing data summaries and analyses in presentations of QA data to departments to help them in formulating responses and improvements, and document discussions of those summaries and analyses in the meeting minutes.
    - Compliance scores: avoid relying on or referencing single overall compliance scores and instead, draw attention to the specific data that indicate a need for action or CAPs.

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

- Since the last review, the Facility Director identified the need for a comprehensive approach to improving Individual Support Plans and set up the ISP Workgroup. After reviewing the Monitoring Team's last report, a group including the Settlement Agreement Coordinator, Qualified Developmental Disabilities (QDDP) Coordinator, the Assistant Director of Programs (ADOP), and the State Office Program Compliance Coordinator identified a number of areas that crossed disciplines and required attention. At a day-long meeting on 1/17/13 that involved all discipline leads, areas of focus were identified including: 1) assessments (i.e., quality,

identifying needed assessments, recommendations related to transition to the community, and timely completion); 2) the ISP meeting (i.e., identifying necessary team members, starting on time, preparation prior to the meeting, draft plans in hand for discussion and finalization, and attendance); 3) documentation following the meeting (i.e., timeliness, complete information, development of good examples of key documents); and 4) plan development and implementation (i.e., meeting implementation timelines, tracking implementation, clinical indicators, and objective development). Action plans were developed for each of these areas, and at the time of the review, they were in various stages of implementation. This was a very positive effort that appeared to be having a beneficial impact in a number of areas.

- Since the last review, LBSSLC had been provided a significant amount of training and technical assistance on the Individual Support Plan process. In April 2013, the State Consultant provided training to all teams on a number of topics related to the ISP process. This included training on goals and the ISP, monthly review, note taking in the ISP, ISP preparation meetings, use of the ISP guide, and the Preferences and Strengths Inventory (PSI) summary. The State Consultant also had been available to provide technical assistance to three pilot teams. Another consulting group provided training and technical assistance on the Functional Skills Assessment (FSA). Discipline Coordinators from State Office also had provided training on the revised Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plans (IHCPs).
- Three pilot teams had been identified to begin use of the revised ISP format and process. Due to the nature of the work that was done at the ISP Preparation Meetings, which occurred 90 days prior to the ISP meetings, some of the meetings that occurred during the week of the onsite review were the first to benefit fully from the revised processes and staff training. It was anticipated that on 7/15/13, all other teams would roll out the new processes.
- Although areas needing improvement were seen throughout the ISP development process, some of the areas in which improvements were seen at the time of this most recent review were in the identification of assessments needed for the ISPs and the timeliness of the completion of assessments. Some important preferences of individuals were being identified through the PSI process, but better summary of this information and use of individuals' preferences and strengths in the ISP action plans were needed. Although still a work in progress, more clinical data was being used in the IRRF process, but ISPs still did not include clinical indicators to assist teams moving forward in determining individuals' health and behavioral health status. The scope of actions plans and IHCPs were increasing, but many protections, services, and supports individuals needed were still missing from the plans, and/or were not individualized and/or measurable.
- The Facility had begun using the revised monthly review format for QDDPs. It was positive that the review process potentially included more data related to skill acquisition plans, as well as review of the other action plans referenced in the ISPs, including the IHCPs. Although deadlines for completion still were not consistently met, timeliness of the monthly reviews had improved. However, concerns continued with regard to the content of the monthly reviews, including the use of data to substantiate status updates, as well as analysis of the data to

provide teams with the information necessary to determine if actions needed to be taken to implement the ISP, train staff, or change the ISP or related plans. In addition, more work was needed to involve other team member in the completion of monthly reviews.

Integrated Clinical Services

- The provider morning meeting with the referral process to the interdisciplinary team (IDT) as needed, along with tracking of several clinical areas, represented a well-integrated approach to clinical care. It also set the expectation of prompt response to concerns and resolution of problems. The provider morning meeting represented nearly all clinical disciplines on a routine basis. Departmental representation was tracked, as were follow-up concerns to post hospital Individual Support Plan Addenda (ISPAs), open record review recommendations, and other clinical concerns needing closure. The attendance by the Qualified Developmental Disabilities Professional (QDDP) Educator provided a mechanism for communication to the IDTs needing to respond to concerns and/or needing to meet to develop an ISPA. The provider morning meeting participants also reviewed the ISPAs for quality of content to ensure the concern was addressed. When not, it was referred back to the IDT, often with additional suggestions and guidance. The consultant reports were reviewed and integrated progress notes (IPNs) were written in response. This occurred in parallel with the provider morning meeting, referring consultation reports to the IDT for an ISPA, if needed.
- It was unclear how the information from the open chart reviews was processed by the IDT, and whether this was included when applicable in a subsequent ISPA. Although copies of the post hospital open record reviews were not requested, a review of the ISPAs demonstrated little to no reference to any findings from the open record reviews. If there were findings, then referencing the findings and including this information in the deliberations and recommendations of the post-hospital ISPA or follow-up ISPA would demonstrate incorporation of this information into the team process. Other areas requiring attention included primary care practitioners' (PCPs') attendance at ISPA meetings at which hospitalizations were being discussed, and timely response to PNMT recommendations requiring PCP orders.
- The Monitoring Team found the Facility was in compliance with Section G.2. This was the result of improvements in the review of and follow-up related to consultation reports.

Minimum Common Elements of Clinical Care

- Several advances were noted with regard to Section H. Records indicated appropriate criteria to justify diagnoses. Several Medical Department quality improvement (QI) tools were added to the existing number, in order to track various aspects of quality care. The provider morning meetings monitored significant change in health status, and several other associated measureable steps were created or continued with follow-up to closure. The QA Department followed medical peer review audit action plans to closure. Periodic assessments (quarterly medical reviews and Quarterly Drug Regimen Reviews) were completed in a timely manner.
- Challenges were also noted. Annual medical assessments and annual dental assessments were timely less than 90 percent of the time. Although most departments were able to submit completed assessments for ISP

preparation in a timely manner, the nursing department lagged in this area. Although the Medical Department created additional QI monitoring tools, development was needed of audit tools to review active records in determining whether common elements of clinical care were provided for various diagnoses, using the clinical guidelines or other resources. Dental annual summaries were based, at times, on data from annual exams completed months prior, rather than ensuring the summaries reflected updated information. For some individuals, there was no record of dental x-rays having been completed, which was problematic when reviewing this section for common elements of clinical care. A number of medical specialty appointments were missed. Evidence needed to be provided that follow-up appointments occurred in a timely manner to ensure common elements of clinical care were in place.

At-Risk Individuals

- Since the last review, the Facility reported that of the 425 staff identified as needing training regarding the Individual Support Plan – At-Risk Individuals procedure, 365 staff (86%) had received the training. Also, additional training was provided to Facility staff by State Office discipline coordinators and/or consultants. The Competency Training Department (CTD) reportedly would be tracking the implementation of the Integrated Health Care Plans (IHCPs), but had not yet developed a tool or received any training at the time of the review.
- In addition, in November 2012, the Facility had begun a mentoring group addressing the systems and documentation for the At-Risk system. The Facility was also in the process of reviewing hospitalization and emergency room data to ensure that Integrated Health Care Plans were in place for these individuals. Also, the Facility had initiated review of its high-risk data and any discrepancies found in the ratings were being reconciled to ensure the reliability of the data.
- Although from the ISP meetings the Monitoring Team observed during the onsite review, some positive changes were noted, there continued to be significant issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.
- Regarding some of the Facility's auditing data for Section I, the Monitoring Team noted that the Facility was incorporating some of the indicators the Monitoring Team used for this area. However, most were not in alignment with the Monitoring Team's indicators and the quality of the assessment documentation was not being reviewed using specific criteria based on discipline-specific standards of practice. However, the Facility did indicate that this would be in process by the next review. In addition, at the time of the review, the Facility recently had decided to defer monitoring activities until all infrastructure systems were solidly in place. Due to the numerous changes to the At-Risk system, the documentation continued to include many deficiencies found by both the Facility and the Monitoring Team. Specifically, the quality of the Integrated Risk Rating Forms (IRRFs) varied, and the Integrated Health Care Plans generally were of poor quality. The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding specific

actions that were taken in response to pertinent events or health issues, and the lack of supporting documentation addressing actions and completion of actions continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the At-Risk system difficult.

Psychiatric Care and Services

- At the time of the Monitoring Team's previous review, LBSSLC had made substantial progress in a number of areas related to Section J. One area of improvement included standardization of the process for completing Comprehensive Psychiatric Assessments (CPAs) in a timely manner, consistent with the specifications of the Settlement Agreement. There also had been considerable progress in decreasing the rates of polypharmacy that could not be clinically justified, and this was sustained.
- The Psychiatry Department continued to employ two full-time Psychiatrists, as well as a part-time Consulting Psychiatrist. Both a full-time Psychiatry Assistant and a Psychiatry Clerk supported the Psychiatrists. The clerical position was added to assist in the gathering of historical information needed to justify the psychotropic medications for the individuals in the Stable Polypharmacy group, as well as maintaining the various databases/spreadsheets needed to sustain their progress for a number of the provisions of the Settlement Agreement.
- A significant remaining issue at the time of the Monitoring Team's previous review was the participation of the Psychiatry Department in the ISP process, as reflected in their participation in the annual meeting and the contributions to the corresponding written documentation. The Monitoring Team's prior report stressed the importance of addressing this issue, which directly affected the requirements of three of the provisions of the Settlement Agreement (i.e., Sections J.8, J.9, and J.10). The current review found that the Psychiatry Department, working in conjunction with the other members of the Interdisciplinary Team, had developed a systematic approach to addressing these issues, while maintaining the progress they had previously made in other areas.

Psychological Care and Services

- Since the Monitoring Team's last review, progress continued with psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing as well in the current peer-based systems implemented to provide internal and external peer review of psychological services.
- Efforts at improving standardized data collection, including effective monitoring and review, was noted. In general, progress was noted with regard to the inclusion of current target and replacement behavior data, including inter-observer agreement (IOA) and integrity data, as well as meaningful summaries of current functioning and implementation for behavioral programming. However, although many of the monthly notes appeared adequate, many were inadequate.
- Review of documentation revealed that most individuals served at LBSSLC, as reported, had a psychological assessment completed or updated within the last 12 months. Continued improvement in the quality of functional assessments, likely due to the revised format and self-monitoring checklist, was also noted. However,

many of these assessments continued to contain outdated results from standardized testing or appeared to inadequately address limitations of previous assessments.

- Progress was noted in the provision and standardization of counseling supports. However, continued efforts directed at ensuring the adequate provision of programs designed to promote generalization by direct support professionals as well as ensure adequate and consistent data collection and monitoring/review of these services are required.
- Continued progress was noted in the development of quality Positive Behavior Support Plans (PBSPs). Efforts aimed at ensuring consistency with regard to adequate operational definitions for replacement behaviors and behavioral objectives for target and replacement behaviors as well as ensuring all PBSPs receive consent and approval prior to implementation are still required.
- Substantial progress was noted in ensuring that PBSPs were written so that direct support professionals could understand them effectively. In addition, improvement was noted with regard to the provision of competency-based training.

Medical Care

- The Medical Department remained fully staffed without turnover. The provider morning meetings were efficient and effective, as well as sustainable. Post-hospital ISPAs, other concerns needing follow-up, and open record reviews all had a rigorous closure system. There were high rates of completion of preventive procedures.
- It was noted that PCPs were not always in attendance at post-hospital ISPAs, and the PCP would be a valuable member of the team at such meetings. Some of the databases appeared to have significant information management problems, which made evaluation difficult. As the Medical Department was not aware of these problems, it appeared the Medical Department had not fully realized that a dependable information management system was necessary to guide the department in planning and implementing quality care initiatives. Attention to the quality of the Medical Department documentation content was needed.

Nursing Care

- Since the last review, nursing staffing continued to be a significant challenge for the Facility, with turnover in a number of staff nursing positions as well as a complete turnover in the key leadership nursing positions. Due to these staffing issues, the Facility had to utilize Agency nurses to cover many of the vacant positions, and continued to do so at the time of the review.
- Some of the Facility's positive steps forward included:
    - A Program Compliance Nurse position was added to the Nursing Department and filled in May 2013 to assume the monitoring responsibilities for nursing.
    - The data from December 2012 through May 2013 indicated that 120 (99%) of 121 total Emergency drills that were conducted were deemed as passing.
    - A review of the Facility's data indicated that the required daily emergency equipment checks completed by Risk Management staff were consistently being conducted.

- The Facility indicated that 100% of current RN Case Managers received training regarding the Individual Support Plan – At Risk Individuals procedure that included training regarding the Integrated Risk Rating Form and the Integrated Health Care Plan. The Facility also indicated that additional training regarding these areas had been provided to the staff by State Office Discipline Coordinators and/or Consultants, and should be completed for all staff by September 2013.
- The Facility implemented a Facility-wide system to decrease medication variances related to medications being given to the wrong individual. It included the training of the direct support professionals regarding their responsibilities during medication administration in assisting the individuals and the nurse.
- Since the last review, the Pharmacy had initiated spot checks audits of the Medication Administration Records and the medication counts across all 15 residences.
- The Facility recently had implemented an enhanced procedure using charting codes in an effort to promote clearer documentation to make it easier to determine the reason for a returned medication.

- Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, the significant regression, found regarding the infection control program, 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 troubling to the Monitoring Team at this stage in the review process. Unfortunately, the challenges in stabilizing the nursing coverage related to staff turnover, and the significant changes made in the nursing leadership positions since the last review had prohibited the Facility from making progress in most of the crucial areas affecting individuals' healthcare. However, it is the hope of the Monitoring Team that the time the Facility took to stabilize its nursing staffing and 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 continued to provide quality services in a number of areas, and had been a valuable participant in assisting other departments (i.e., the Medical, and Nursing Departments). Quarterly Drug Regimen Reviews (QDRRs) remained current. New orders were processed efficiently and with quality reviews prior to dispensing. There had been professional staff training on adverse drug reactions (ADRs), and drug utilization reviews (DUEs) were completed in a timely manner and appeared to be helpful to the clinical practice of the PCPs.
- The Pharmacy Department had continued to provide technical support and increased monitoring in attempting to reduce the unexplained returned medications. This remained a challenge, because the problem remained unresolved, and there were significant potential clinical implications. In reviewing the appropriateness and safety of polypharmacy, a review of drug-drug interactions would be appropriate. In addition, improvement was needed in the quality of the Psychiatry and Pharmacy Departments' completion of chemical restraint forms, so that sufficient information was available to guide staff in analysis and decision-making.

- The Monitoring Team found the Facility to be in substantial compliance with Sections N.1, N.2, N.4, N.5, N.6, and N.7.

Physical and Nutritional Supports

- The Facility's Physical and Nutritional Management Team (PNMT) had the required core members as outlined in the Settlement Agreement, and was meeting regularly. However, a review of PNMT documentation did not support routine participation by medical providers.
- The Facility PNMT policy had been revised, but necessary components were missing to define the monitoring process.
- The PNMT had made significant progress in the production of comprehensive PNMT assessments.
- Since the Monitoring Team's last review, progress had been made with individuals' Physical and Nutritional Management Plans (PNMPs) having more of the necessary components. The Facility had developed and implemented a PNMP audit tool.
- The Monitoring Team, members of the PNMT, Facility therapists, leadership staff of the Mealtime Coordinator Committee (i.e., Active Treatment Coordinator and Safety Officer) completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk.
- The Facility had made substantial progress in the provision of physical and nutritional management (PNM) foundational training for new employees and veteran staff. Additional work was needed to ensure staff providing supports to individuals received individual-specific training.
- The Facility had not implemented an effectiveness monitoring system to assess individuals' progress in relation to their physical and nutritional management needs, or provide evidence that interventions were modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' 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 maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have formal plans.

Physical and Occupational Therapy

- The seven individuals newly admitted to the Facility received an Occupational Therapy/Physical Therapy (OT/PT) assessment within 30 days. However, individuals who had experienced a change in status had not received an assessment update. Individuals' OT/PT assessments were missing some of the components necessary to fully assess an individual's OT/PT functional status, provide an analysis of whether or not current

supports and services were effective, and as appropriate, recommend new services or skill acquisition programs to improve the individual's functioning, health, and/or independence.

- Individuals receiving direct OT/PT interventions did not have plans. As a result, these plans and/or programs were not integrated into individuals' ISPs. In addition, there were no monthly progress notes reviewing the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports.
- On a positive note, the Facility was tracking the completion of requested wheelchair repairs.

Dental Services

- The Dental Department continued to provide a full array of dental services. There were no adverse events following total intravenous anesthesia (TIVA)/general anesthesia administration. A flossing program was started with three individuals. A small percentage of the population was edentulous. The new dental database software appeared to be functional. There was a high rate of individuals that brushed their own teeth.
- There continued to be numerous challenges. The annual examination reports did not include meaningful dental treatment plans. At times, the annual dental summary was based on outdated annual dental assessments. There was no Dental Department quality improvement initiative. Review of dental services was only accomplished through the QA Department. For those identified as needing or benefitting from a suction tooth brushing, but without access, there did not appear to be a quick resolution in obtaining the equipment and resolving the challenges. Some follow-up visits for missed appointments appeared delayed for months. The Dental Department did not aggressively resolve the many refused and missed appointments. There remained many policies and procedures in draft form.
- For the prior six months, there were 307 completed dental appointments. Although none of the appointments utilized mechanical restraints, and only one utilized oral sedation, 60 appointments (20%) utilized general anesthesia/TIVA. The risk/benefit of oral sedation versus TIVA/general anesthesia was not well defined. It appeared that the Dental Department considered TIVA/general anesthesia less of a risk to administer than any level of oral sedation. Rationale of risk/benefit needed to be documented and supported by dental references and standards. Rationale of least restrictive approach using oral sedation versus TIVA/general anesthesia also needed documentation.

Communication

- The Facility had four Speech Language Pathologists (SLPs), but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at LBSSLC.
- Seven of the seven individuals newly admitted to LBSSLC had communication assessments completed within 30 days. The Facility continued to make significant progress on improving individuals' communication assessments. Although further work was needed to include all of the necessary components, the assessments had begun to provide some important information to teams.

- ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use alternative and augmentative communication (AAC) devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. It could not be determined if individuals who received direct speech/language (SL) therapy interventions had their plans initiated in a timely manner. Progress notes did not include necessary components.
- Observations of individuals with AAC systems revealed that some systems were present and/or being used. However, for some individuals the device was not present, broken, and/or not in use. During some observations, staff did not understand how to engage individuals with the systems. Individual-specific staff training and performance check-offs for individuals with AAC devices was an area requiring additional work.
- The Facility did not have a policy and/or procedure for monitoring communication supports. Individuals with AAC systems had been monitored using the Compliance Monitoring form, but not on a consistent basis.

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

- Efforts to support the development of quality Skill Acquisition Programs (SAPs) was noted. This included the addition of new staff, a new SAP format, a new SAP development curriculum, and the utilization of a new quality assessment tool. However, significant concerns remained regarding the quality of SAPs, including ongoing data collection, monitoring, and adequate review. That is, although it appeared that the Facility was improving the resources and processes necessary to support the development of quality programming, the Facility still appeared to be in the midst of transition regarding the effective development, implementation, and monitoring of SAPs. Indeed, concerns regarding the quality and adequacy of monitoring were noted across all sampled SAPs, including dental and medical desensitization plans. Consequently, it continued to be unlikely that the majority of skill acquisition programs were currently promoting growth, development, and independence for individuals served at LBSSLC.
- Estimates of engagement during the onsite visit were consistent with previously estimated levels. This finding was inconsistent with estimates the Facility reported. However, it should be noted that QA and active treatment staff continued to utilize different tools when conducting engagement probes.
- Substantial efforts aimed at training staff in the areas of active treatment, including engagement and SAPs, was evident. However, inadequacies in training materials as well as in efforts aimed at ensuring implementation integrity, including inter-rater agreement, were noted. In addition, efforts directed at supporting day and vocational programming were noted, but these supports had not yet evidenced measureable progress in providing on- or off-campus employment opportunities.
- Progress was observed in the area of conducting annual assessments targeting individuals' preferences, strengths, skills, and needs, including in the areas of living, working, and engaging in leisure activities. However, concerns regarding the adequacy of completed PSI, FSAs, and vocational assessments remained.

- Lastly, most of the individuals sampled appeared to have one or more SAPs that identified the community as a potential setting to facilitate generalization. However, concerns regarding adequate and sufficient opportunities for skill acquisition in community settings, including the lack of a systematic method for monitoring individual performance over time, continued to be observed. Similarly, opportunities for community integration continued to remain inadequate for many of the individuals residing in the Facility.

Most Integrated Setting

- Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community. In addition, individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. Based on observations of ISP meetings, when team members modified the opinions they had included in their assessments, generally no explanation was provided.
- During the interview with staff from the Admissions Placement Department, staff indicated that some individuals had been removed from the referral list due to family members becoming guardians and rescinding the referrals. Of concern, staff stated that the Admissions Placement Department had told teams to work on educating family members prior to making a referral to convince them to become guardian before the referrals were made. As the State Office staff member observing the interview pointed out, other Facilities were approaching this differently, and having the Transition Specialists work with family member that were not guardians, but had concerns about transition. The Transition Specialists at other Facilities were, for example, identifying the family members' concerns in more detail, and assisting in answering questions and identifying community providers that had a record of providing specific supports that family members might not think were available in community settings. As opposed to LBSSLC's stated approach, this latter approach was consistent with the portion of this provision of the Settlement Agreement that required the State to: "take action to encourage and assist individuals to move to the most integrated settings…"
- Although teams were identifying obstacles to referral, they often did not include all of the concerns the team had identified in their discussion. This resulted in action plans not being developed for all obstacles. In addition, action plans that were being developed were poor in that they often did not address the underlying issue, and were not individualized. It remained unclear if teams were regularly identifying obstacles to transition. Similarly, the Facility continued to provide a number of educational opportunities to individuals and their families. However, an ongoing concern was the lack of individualization of action plans related to expanding individuals and their guardian's knowledge of supports in the community that could meet their needs.
- 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' Community Living Discharge Plans (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.

- Based on review of documentation related to potentially negative outcomes for individuals that had transitioned to the community, eight of 10 individuals had been involved in one or more incident. In recent months, three individuals that had transitioned to the community since the Settlement Agreement was signed had returned to the Facility, and two of these individuals were in jail before returning. Although further analysis of this information would be needed to draw conclusions, the Facility was not conducting root cause analysis reviews of even the most critical incidents. This was an important and missing component of the quality assurance system for Section T. Although different reasons likely existed for the various individuals' experiences, it is very important that critical reviews of these situations be conducted to determine what, if anything, could be done from the perspective of the transition process and/or the community system to prevent similar outcomes in the future for these or other individuals.
- 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. Post-move monitoring had been completed in a timely manner. Although it was clear that efforts were being made to conduct thorough post-move monitoring, 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.

<u>Consent</u>

- As previously reported, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. LBSSLC had adopted and individualized the State Office Guardianship policy and had begun to implement portions of the policy.
- Since the last review, the Facility had developed a Guardianship Committee and it had begun to meet. The Committee included mostly Facility staff, but one community member was on the Committee, and the Human Rights Officer was working on identifying additional community members. Further efforts were being made to solicit more community members.
- 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 or process. LBSSLC had begun to work with teams to identify current assessments that would assist in this process. They had identified some, but not all of the relevant assessments. In addition to identifying the specific tests or components of assessments that would need to be considered, a standardized tool/process would need to take into account assessment of whether or

not alternatives to guardianship would be a viable less restrictive option. 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 6/17/13, included names of 75 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 36% were estimated to need guardians (i.e., all individuals who did not currently have guardians). Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 35 individuals had a Priority I need for guardianship, 34 individuals were in the Priority II category, and six 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 resulted in guardians being appointed for 11 individuals, with another seven individuals in some phase of the process.
- For individuals who did lack the functional capacity to make decisions, but who did not have family or other interested parties involved, it remained unclear what, if any guardianship resources were available. Although some Facility staff had been appointed or were pursuing guardianship for individuals at LBSSLC, the potential conflicts of interest this presented were discussed with Facility and State Office staff.

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

- According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. The Facility recognized that a next step was addressing some of the issues that monitoring showed with regard to the requirements of Appendix D of the Settlement Agreement, including issues related to the quality of the records.
- Since the last review, 27 procedures were developed or revised, and training had been completed on 20 of the 27. Training was in process for the remaining, more recently issued procedures. Since the last review, the Competency Training Department had developed and implemented a system to track the completion of training on each of the new/revised policies. Reports showing which staff had completed the training were submitted. Email correspondence documented when the staff requiring training had completed the training. This represented significant progress since the last review.
- 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 a number of problems with the records. The Facility recognized that the next step would be aggregating and analyzing information gained through record audits in more depth to determine if specific corrective action was needed. Using monitoring data, the Facility also had recently taken action to address issues related to checking records out and in whenever they were removed from the residences. It was positive that the Facility was using data in this way, and that the Facility recognized the need to do deeper analysis of other data it was collecting.
- 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.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Sample #C.1: the restraint checklist form, face-to-face/debriefing form, the individual's Crisis Intervention Plan (CIP), if applicable, documentation of reviews of this use of restraint, and any addenda or resulting changes to the ISP or Safety Plan were reviewed for the restraints listed in the following table.
<table>
<tr><th>Sample Identification #</th><th>Individual #</th><th>Date and time</th></tr>
<tr><td>1.</td><td>Individual #284</td><td>5/6/13 at 2:34 p.m.</td></tr>
<tr><td>2.</td><td>Individual #51</td><td>4/19/13 at 4:30 a.m.</td></tr>
<tr><td>3.</td><td>Individual #213</td><td>4/12/13 at 9:17 a.m.</td></tr>
<tr><td>4.</td><td>Individual #288</td><td>11/15/12 at 9:50 p.m.</td></tr>
<tr><td>5.</td><td>Individual #46</td><td>3/2/13 at 4:02 p.m.</td></tr>
<tr><td>6.</td><td>Individual #46</td><td>2/23/13 at 5:34 p.m.</td></tr>
<tr><td>7.</td><td>Individual #46</td><td>3/16/13 at 3:45 p.m.</td></tr>
<tr><td>8.</td><td>Individual #288</td><td>5/6/13 at 5:12 p.m.</td></tr>
<tr><td>9.</td><td>Individual #213</td><td>3/18/13 at 12:34 p.m.</td></tr>
<tr><td>10.</td><td>Individual #27</td><td>11/26/12 at 8:11 p.m.</td></tr>
<tr><td>11.</td><td>Individual #320</td><td>4/30/13 at 8:10 p.m.</td></tr>
<tr><td>12.</td><td>Individual #131</td><td>3/20/13 at 11:17 a.m.</td></tr>
<tr><td>13.</td><td>Individual #64</td><td>1/28/13 at 5:51 p.m.</td></tr>
<tr><td>14.</td><td>Individual #124</td><td>3/10/13 at 7:30 p.m.</td></tr>
<tr><td>15.</td><td>Individual #51</td><td>4/19/13 at 1:33 a.m.</td></tr>
<tr><td>16.</td><td>Individual #51</td><td>4/19/13 at 3:45 a.m.</td></tr>
<tr><td>17.</td><td>Individual #51</td><td>4/19/13 at 3:55 a.m.</td></tr>
<tr><td>18.</td><td>Individual #61</td><td>1/15/13 at 7:19 a.m.</td></tr>
<tr><td>19.</td><td>Individual #239</td><td>12/18/12 at 3:45 a.m.</td></tr>
<tr><td>20.</td><td>Individual #240</td><td>4/13/13 at 9:41 p.m.</td></tr>
<tr><td>21.</td><td>Individual #154</td><td>11/21/12 at 10:52 p.m.</td></tr>
<tr><td>22.</td><td>Individual #155</td><td>4/22/13 at 12:47 p.m.</td></tr>
<tr><td>23.</td><td>Individual #40</td><td>4/29/13 at 10:32 a.m.</td></tr>
</table>
</td></tr>
</table>

24.	Individual #38	4/19/13 at 4:16 p.m.
25.	Individual #279	3/11/13 at 12:06 p.m.
26.	Individual #251	4/15/13 at 10:01 a.m.
27.	Individual #4	12/26/12 at 12:44 p.m.
28.	Individual #320	3/19/13 at 2:40 p.m.
29.	Individual #57	12/2/12 at 9:20 a.m.
30.	Individual #36	11/19/12 at 7:12 p.m.

- **Sample #C.2**: The following documentation for a selected sample of 24 staff was requested: their start dates, the dates they were assigned to work with individuals, their training transcripts showing date of most recent PMAB training, and training on use of restraints;
- **Sample #C.3**: Medical Restraint Sample: From the list provided in response to document request II.7 of 22 restraint reports involving, individuals with medical restraints, not including approximately 110 medical restraints of one individual to prevent accidental dislodgement of a feeding tube until a button device could be installed. A sample of four records was drawn as in the following table. Each record included: the restraint checklist, documentation of the monitoring of the restraint, any reviews of the use of restraint, any desensitization plan or other plan to reduce the use of restraint that may apply, the doctor's order for the restraint, including the monitoring schedule to be used and the medical restraint plan.

Sample Identification #	Name	Date
1.	Individual #318	4/11/13 at 9:00 a.m.
2.	Individual #57	1/22/13 at 11:00 a.m.
3.	Individual #175	2/5/13 at 12:30 p.m.
4.	Individual #6	5/15/13 at 6:00 a.m.

- **Sample #C.4:** Chemical Restraint Sample: From the list provided in response to document request II.7, the total chemical restraints for crisis intervention was 37. Sample size was six, or 16%, and included the restraint checklist, the face to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. The following table identifies the sample:

Sample Identification #	Name	Date and Time
1.	Individual #284	5/6/13 at 2:34 p.m.
2.	Individual #51	4/19/13 at 4:30 a.m.

3.	Individual #213	4/12/13 at 9:17 a.m.
4.	Individual #288	11/15/12 at 9:50 p.m.
5.	Individual #46	3/2/13 at 4:02 p.m.
6.	Individual #46	2/23/13 at 5:34 p.m.

- **Sample #C.5:** The following records for all three of the records for individuals with restraints off-grounds, including**:** the Restraint Checklist, the face-to-face/debriefing form, the Crisis Intervention Plan, any reviews of the use of this restraint, and any addenda or changes to the individual's ISP or Crisis Intervention plan that resulted. The three records were:

Sample Identification #	Name	Off-grounds Restraint
1.	Individual #320	1/27/13 at 8:10 a.m.
2.	Individual #320	1/27/13 at 9:10 a.m.
3.	Individual #124	3/7/13 at 3:18 p.m.

- **Sample #C.6** four individuals who were restrained more than three times in a 30-day period, with a total of 18 restraints, were selected from the list of individuals restrained as crisis intervention between November 2012 and May 2013. Restraint records were requested, including Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Reports, Crisis Intervention Restraint Plans, Individual Support Plans (ISP), ISP Addendums, Positive Behavior Support Plans (PBSP), and Monthly Behavioral Services Reviews (for the current month as well as the preceding and following months), as available, for the following individuals for restraints on the following dates and times:

Individual	Date of Restraint	Time of Restraint
Individual #46	3/29/13	8:00 a.m.
	4/20/13	8:30 a.m.
	4/20/13	8:35 a.m.
	4/22/13	10:30 a.m.
Individual #131	3/18/13	9:37 a.m.
	3/20/13	11:17 a.m.
	3/21/13	2:10 p.m.
	4/6/13	3:35 p.m.
Individual #64	2/14/13	9:17 a.m.
	2/20/13	5:33 p.m.
	3/4/13	2:00 p.m.
	3/4/13	2:13 p.m.
Individual # 51	3/22/13	11:48 a.m.

	3/22/13	11:19 a.m. (Chemical)
	4/19/13	1:33 a.m.
	4/19/13	3:45 a.m.
	4/19/13	3:55 a.m.
	4/19/13	4:30 a.m. (Chemical)

- **Sample #C.7:** Protective Mechanical Restraints to Prevent Self-Injurious Behavior (PMR-SIB): the Restraint Checklist, the face to face/debriefing report, the documentation of monitoring of the restraint, the order for the restraint and any alternate schedule of monitoring, the ISP confirming the use of the restraint, any and all reviews of the use of the restraint, and the list of Facility approved restraints with policy reference were requested for the following restraint episodes:

Sample identification #	Name	Date	Type
1.	Individual #242	2/13/13	Protective Mechanical
2.	Individual #242	4/13/13	Protective Mechanical
3.	Individual #242	5/7/13	Protective Mechanical
4.	Individual #6	5/15/13	Listed as medical/dental appeared to be protective mechanical

- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals:
  - Individual #284 on 5/6/13 at 2:34 p.m.;
  - Individual #51 on 4/19/13 at 4:30 a.m., and 4/19/13 at 1:33 a.m.;
  - Individual #213 on 4/12/13 at 9:17 a.m., and 3/18/13 at 12:34 p.m.;
  - Individual #288 on 11/15/12 at 9:50 p.m., and 5/6/13 at 5:12 p.m.;
  - Individual #46 on 3/2/13 at 4:02 p.m.; 2/23/13 at 5:34 p.m., and 3/16/13 at 3:45 p.m.;
  - Individual #27 on 11/26/12 at 8:11 p.m.;
  - Individual #320 on 4/30/13 at 8:10 p.m., and 3/19/13 at 2:40 p.m.;
  - Individual #131 on 3/20/13 at 11:17 a.m.;
  - Individual #64 on 1/28/13 at 5:51 p.m.;
  - Individual #124 on 3/10/13 at 7:30 p.m.;
  - Individual #61 on 1/15/13 at 7:19 a.m.;
  - Individual #239 on 12/18/12 at 3:45 a.m.;
  - Individual #240 on 4/13/13 at 9:41 p.m.;
  - Individual #154 on 11/21/12 at 10:52 p.m.;
  - Individual #155 on 4/22/13 at 12:47 p.m.;

	• Individual #40 on 4/29/13 at 10:32 a.m.; • Individual #38 on 4/19/13 at 4:16 p.m.; • Individual #279 on 3/11/13 at 12:06 p.m.; • Individual #251 on 4/15/13 at 10:01 a.m.; • Individual #4 on 12/26/12 at 12:44 p.m.; • Individual #57 on 12/2/12 at 9:20 a.m., and; • Individual #36 on 11/19/12 at 7:12 p.m.; o The Crisis Intervention Restraint Checklist, February 2013; o SSLC 001C Protective Mechanical Restraint for Self-Injurious Behavior checklist, February 2013; o SSLC 001B Medical/Dental Restraint Checklist, February 2013; o List of restraints, from November 2012 through May 2013; o Presentation Book for Section C; o LBSSLC Policy, "Limitations of Restraint," revised 7/12/12; o Completed Monitoring Tools for Section C; o Self-Assessment for Section C, dated 6/20/13; o Action Plans: Section C, dated 6/20/13; o Residential Monitors: from 1/1/12 to 6/7/13; o Minutes of the Quality Assurance/Quality Improvement Committee, for November and December 2012 and February, March, and April 2013. o For the last year, list of injuries by individual, living area, and by type; o Injuries During the Use of Restraint for individuals and staff, dated from 5/15/12 through 5/15/13; o Positive Behavior Support Plans (PBSPs), as available, for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; and o Staff Injuries During the Use of Restraint, 5/15/12 through 5/15/13. ▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs (ADOP); o Jim Forbes, M.Ed., BCBA, Director of Behavioral Services; and Carolyn Milton, Assistant Director of Behavioral Services, on 7/8/13 and 7/9/13; o Dawn Ripley, Director of Quality Assurance; o Brandi Villarreal, RN, BSN, Chief Nurse Executive (CNE); o Lilly Burton, RN, Program Compliance Nurse; o Ruth Clark, RN, Quality Assurance Nurse; and o Interviews with 10 staff concerning their knowledge of basic restraint rules. ▪ **Observations of**: o Site visits to nine living residences (513, 514, 515, 516, 517, 518, 523, 525 and 526), and the workshop;

	o Incident Management Review Team (IMRT) Meeting, on 7/10/13; o Executive Safety Committee meeting, on 7/11/13; o Quality Assurance/Quality Improvement (QAQI) Committee meeting, on 10/3/12; o Self-Advocacy meeting, on 7/9/13; o Unit I and II morning meeting, on 7/10/13; and o Individual #242 at home, on 7/11/13.
	Facility Self-Assessment: The Lubbock State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance with three of the 14 provisions in Section C of the Settlement Agreement. The Monitoring Team found the Facility to be in substantial compliance with the same three of the 14 provisions. In its Self-Assessment, dated 6/20/13, 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. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, and interviews with staff: ▪ 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, Revised July 2012." 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. While that list was not provided as a monitoring tool, from reviewing it on site, the checklist appeared to capture the key Settlement Agreement requirements. ▪ 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. Information from other sources was sometimes used, such as video monitoring for prone restraints. ▪ 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. Although this was not specifically stated in the Facility's Self-Assessment, the Facility had decided that Behavioral Services Department must monitor and assess all restraints for compliance with State and Facility policy. Thus, sample sizes were adequate to consider them more than representative samples. ▪ The monitoring/audit tools, used by the Program Compliance Monitors (PCMs) included instructions/guidelines, which were generally adequate to ensure consistency in monitoring. The checklist being used by the Director of Behavioral Services and one staff member assigned to reviews did not have guidelines. ▪ 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. However, during the site visit, interview with the Director of Behavioral Services confirmed the role he played in monitoring restraint use and that one person on his staff was responsible for auditing restraint documents. ▪ 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. ▪ The Facility used some relevant data sources and/or was beginning use of some key indicators/outcome measures. For example, in addition to conducting audits, the Facility used data sources such as its training database. Much work had been done to develop key indicators (performance indicators) as explained in more detail with regard to Section E of this report. Five indicators had been selected for Section C. No baselines had been specified nor targets assigned. However, these indicators provided a place to begin using indicators. ▪ The Facility consistently presented some of the data in a meaningful/useful way, but some issues were noted. 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 (such as the depth and scope) of the reviews. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ 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: During this review, the Monitoring Team found the Facility to be in substantial compliance with three out of 14 provisions of Section D, as opposed to two provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ The self-assessment based its determinations on data and pointed out issues. ▪ The Facility had a process for updating and posting the Do Not Restrain. ▪ Trend reports tracked restraints over time and over a variety of factors, providing useful information. These reports could be used to identify both systemic and individual issues in need, or corrective action. ▪ Performance indicators had been selected and while they had not been completely developed or implemented, this was a good start. Some of the areas in which improvements were necessary for the Facility to progress toward substantial compliance with all of Section C of the Settlement Agreement included the need to: ▪ Work to produce consistent and timely reviews by interdisciplinary teams (IDTs) of restraints

	that occur more than three times in a 30-day period or that are requested in response to data collected in the restraint review process. ▪ Work with nursing on the timeliness and quality of nursing assessments of people who have been restrained. ▪ Continue to mine the data for issues that may respond to a corrective action plan approach to solution.

<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>A review of the data provided by the Facility for the following table showed:

<table>
<tr><th>Type of Restraint</th><th>5/1/12 to 10/30/12</th><th>11/1/12 to 4/30/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>114</td><td>158</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>17</td><td>38</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0*</td><td>0*</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>131</td><td>196</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>23</td><td>21</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>3</td><td>7</td></tr>
<tr><td>Medical/dental restraints</td><td>27</td><td>127**</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>23</td><td>16</td></tr>
</table>
* Did not include protective mechanical restraints for self-injurious behavior
** Included 91 mechanical restraints used for Individual #6 from February through May 2013. The restraint had been categorized as a protective mechanical restraint, but upon further review, it was revised to medical/dental restraint. This appeared to be an appropriate action, since the evidence indicated the restraint was in place to prevent accidental dislodgement of a feeding tube until a mic-key button was installed. Once that was accomplished, the restraint was discontinued.

<u>Prone Restraint</u>
a. Based on Facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected. (A list is provided in the Documents</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Reviewed Section above.) c. Based on a review of the restraint records for individuals in Sample #C.1 involving 23 individuals, 0 (0%) showed use of prone restraint. d. Based on interviews with 10 direct support professionals, all were aware of the prohibition on prone restraint. <u>Other Restraint Requirements</u> e. Based on document review, the Facility and State policies state 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms for 24 physical restraints and six chemical restraints. The following are the results of this review: ▪ f. In 30 of the 30 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. ▪ g. For the 30 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 30 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. ▪ h. In 29 of the records (97%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. In one, Sample #C.1.14, efforts were not documented to de-escalate the situation prior to restraint, and this was noted in the debriefing sheet. ▪ i. Facility policies identified a list of approved restraints. The Director of Behavioral Services pointed out that the list of restraints incorporated into the Restraint Checklist and appended to the State policy include the list of approved restraints, and that LBSSLC was only using restraints found on that list. . ▪ j. Based on the review of 30 restraints, involving 22 individuals, all (100%) were approved restraints.	

#	Provision	Assessment of Status	Compliance
		• k. In 28 of these records (93%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Examples where this was not the case included Sample #C.1.1 where the individual was found rubbing his hands until the skin was compromised, and it was not clear what, if any, treatment such as activities or programs staff had made available to him prior to the incident to promote healthy interaction with his environment. In Sample #C.1.7, the individual was seeking a CD from staff to play in his machine. Staff had CDs, but could not tell which might be his and so did not fulfill his request. It appeared that this individual was attempting to engage in positive behavior as was part of his plan, but was prevented from doing so by the confusion over the CDs. If the CDs had been marked with the name of their owners, or if there were CDs available to all, this restraint might have been avoided. • l. Of the 110 restraints for one individual between November 2012 and May 2013, that were considered to be PMR-SIB by the Facility, all were for the same person. Three of those records were reviewed (Sample #C.7). Of these, three (100%) followed state policy regarding the use, management, and review of PMR. However, some details of the use of PMR-SIB needed to be clarified such as: whether there is a specified time between circulation checks of the device. This was not specified, though most checks were done hourly or every other hour. Based on this review, the Facility was found to be in substantial compliance. The Facility Self Assessment found substantial compliance as well.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Twenty-four physical restraint records involving the 21 individuals in Sample #C.1 were reviewed. Of these, eight of the individuals had Crisis Intervention Plans that defined the use of restraint. a. There were eight active CIPs at the time of the physical restraints in Sample #C.1 (i.e., through May 2013). Of those, in three restraints, the individuals were released due to inability to maintain. Of the remaining five, four (80%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. The one that did not was Sample #C.1.7, where the CIP called for attempted release after 15 minutes, but the documentation indicated a release after 29 minutes with no explanation. The individual was being restrained to allow for administration of a chemical restraint. b. There were 18 restraints for 13 individuals who did not have Crisis Intervention Plans.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Of those, one involved an early release of restraint due to inability to maintain. Of the 17 remaining restraints, 17 (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review, the Facility remained in substantial compliance with this provision. While the metric (a) calculates at 80%, there was only one deviation from the requirement to terminate as soon as the individual is no longer a danger in 26 uses of restraint. Facility policy required that there be documented attempts to release at 15 minutes and the CIP specified that attempt be made at 15 minutes. However, that one lapse did not appear to be representative of significant problems with prompt release. The Facility Self-assessment also found substantial compliance.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided in the Documents Reviewed section above. b. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. ▪ 4 of the 4 (100%) had completed Prevention and Management of Aggressive Behavior (PMAB) training within the past 12 months. ▪ 20 of the 20 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint? (100%); ▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques (100%); and ▪ How would you supervise an individual in restraint? (100%).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		d. In 29 of the records (97%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review, the Facility remained in substantial compliance with this provision. The Facility Self-assessment found the same.	
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.	a. Based on a review of 30 restraint records (Sample #C.1), in 30 (100%) there was evidence that documented the restraint was used as a crisis intervention. b. A sample of 14 PBSPs were selected and reviewed to examine whether or not restraints were used for anything other than crisis intervention. Based on the PBSP Master List, dated 7/11/13, this sample reflected approximately 10% of the total number of PBSPs currently in place (N=135). Of the 14 PBSPs reviewed, in 14 (100%), there was 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. c. In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. As discussed in previous reports, the State and Facility policies included the provision for Protective Mechanical Restraint for Self-Injurious Behavior. The policy defined PMR-SIB as "a type of mechanical restraint applied prior to the individual engaging in self-injurious behavior for the purpose of preventing or mitigating the danger of the self-injurious behavior because there is evidence that: (1) the targeted behavior can result in serious self-injury when it does occur and (2) intensive, even one-to-one supervision and treatment have not yet reduced the danger of self-injury." In the records reviewed for this report, there was one individual with a PMR-SIB restraint in use as described with regard to Section C.1 above. An observation of the individual, discussion with the Director of Behavioral Services, and a sample of the restraint records for this individual indicated that the restraint was necessary to avert a crisis and was being used according to the policy. d. In 30 of 30 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 maintained by the Facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Three records were selected for additional review to determine if there were medical issues to contraindicate use of restraint. Those records were for Sample #C.1.10, Sample #C.1.15, and Sample #C.1.20. e. In three of three physical restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the signature on the Restraint Checklist documenting the order of the physician for the restraint. f. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan, based on a review of the records provided. Members of the Monitoring Team recently attended a meeting of the Facility's Desensitization Committee, and it was clear that the Committee was working to revise the process utilized by IDTs in identifying individuals who would require more intensive support (i.e., medical or dental desensitization plans). Consequently, it appeared that any previously submitted or currently provided data describing the total number of individuals identified for medical and/or dental desensitization would likely change. During the meeting, the Committee recommended holding subsequent monthly meetings with the goal of revising the guidelines, including defining important terms (e.g., what is a "routine" dental procedure) and classifications, that IDTs would use when assessing the needs of individuals and making recommendations for formal treatment with regard to medical and/or dental supports or restraints. As noted in the previous Monitoring Team report, 97 dental desensitization plans and 24 medical desensitization plans had been completed. Currently, based on provided documentation, as of May 2013, 113 dental desensitization plans and 24 medical desensitization plans were in place. However, verbal reports during the Desensitization Committee suggested that the number of individuals with dental desensitization plans was recently reduced to approximately 37. Members of the committee indicated that this reduction was related to recent changes in definitions of relevant terms as well as how some dental procedures were re-categorized. Consequently, as noted above, the current status of the identification process was undergoing revision and the numbers of individuals with desensitization plans was predicted to change in the future. Nonetheless, an examination of a sample of current desensitization plans was completed and specific findings regarding the quality of sampled plans were discussed with regard to Section S.1 of the Settlement Agreement. As reported with regard to Section S.1, a small sample of medical and dental desensitization SAPs, in addition to a larger random sample of SAPs, were reviewed. This review of medical and dental desensitization SAPs focused primarily on the quality of SAPs and did not include an examination of related ISPs, consents, and data for those individuals within the sample. Based on the current	

#	Provision	Assessment of Status	Compliance
		review of sampled medical and dental desensitization SAPs: ▪ g. The following metric will be reviewed during upcoming reviews: ___ (%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); ▪ h. Zero (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and ▪ i. Given that none of the current SAPs were sufficient, the following metric will be reviewed during upcoming reviews: ___ (%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Based on this review, the Facility remained out of compliance with this provision, due to ongoing concerns regarding the lack of sufficient treatments or strategies to minimize or eliminate the need for restraint.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional	In accordance with the new policy directives, restraint checklists had been revised. Staff has been trained on both the new policy and the use of the restraint checklists and other forms. a. Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. c. Based on review of training records and information the Facility provided in response to the draft report, 13 of 14 staff at the Facility who performed the duties of a restraint monitor (93%) for restraints in Sample #C.1 successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. The name of the staff who was listed as a restraint monitor in records: Sample #C.1.5 did not appear on the list of Restraint Monitors. Based on a review of 30 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ d. In 29 out of 30 incidents of restraint (97%) by an adequately trained staff member. Records that did not contain documentation of this included: Sample #C.1.5, since the names of the restraint monitor did not appear on the provided list of trained Restraint Monitors. ▪ e. In 30 out of 30 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. However as noted in (d) above, in four records the restraint monitor was not on the list of staff that had been trained. ▪ f. In 30 instances (100%), the documentation showed that an assessment was	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	completed of the application of the restraint. ▪ g. In 30 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. There were no records in Sample # C.1 and no records of any alternative schedules of monitoring were reported by the Facility. If any had been identified the following would have been assessed. ▪ h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 28 restraint records for 22 individuals for restraints that occurred at the Facility (i.e., Individual #284, Individual #51, Individual #213, Individual #288, Individual #46, Individual #27, Individual #320, Individual #131, Individual #64, Individual #124, Individual #61, Individual #239, Individual #240, Individual #154, Individual #155, Individual #40, Individual #38, Individual #279, Individual #251, Individual #4, Individual #57, and Individual #36), there was documentation that a licensed health care professional: ▪ j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 22 (79%) of the instances of restraint. Records that did not contain documentation of this included: Individual #46 on 3/16/13 at 3:45 p.m.; Individual #131 on 3/20/13 at 11:17 a.m.; Individual #61 on 1/15/13 at 7:19 a.m.; Individual #155 on 4/22/13 at 12:47 p.m.; Individual #279 on 3/11/13 at 12:06 p.m.; and Individual 251 on 4/15/13 at 10:01 a.m. ▪ k. Monitored and documented vital signs in 15 (54%) episodes. Records that did not contain appropriate documentation of this included: Individual #51 on 4/19/13 at 4:30 a.m., and 4/19/13 at 1:33 a.m.; Individual #46 on 3/16/13 at 3:45 p.m.; Individual #288 on 5/6/13 at 5:12 p.m.; Individual #213 on 3/18/13 at 12:34 p.m.; Individual #320 on 4/30/13 at 8:10 p.m., and 3/19/13 at 2:40 p.m.; Individual #124 on 3/10/13 at 7:30 p.m.; Individual #61 on 1/15/13 at 7:19 a.m.; Individual #240 on 4/13/13 at 9:41 p.m.; Individual #40 on 4/29/13 at 10:32 a.m.; Individual #4 on 12/26/12 at 12:44 p.m.; and Individual #36 on 11/19/12 at 7:12 p.m. Problematic issues resulting in noncompliance included variations in the vital signs not retaken, vital signs not recorded, or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. ▪ l. Monitored and documented mental status in 17 (61%) episodes. Records that did not contain appropriate documentation of this included: Individual #284 on 5/6/13 at 2:34 p.m.; Individual #51 on 4/19/13 at 4:30 a.m.; Individual #46 on 3/2/13 at 4:02 p.m., and 3/16/13 at 3:45 p.m.; Individual #61 on 1/15/13 at 7:19 a.m.; Individual #239 on 12/18/12 at 3:45 a.m.; Individual #154 on	

#	Provision	Assessment of Status	Compliance
		11/21/12 at 10:52 p.m.; Individual #40 on 4/29/13 at 10:32 a.m.; Individual #38 on 4/19/13 at 4:16 p.m.; Individual #320 on 3/19/13 at 2:40 p.m.; and Individual #36 on 11/19/12 at 7:12 p.m. Problematic issues resulting in noncompliance included either the mental status was not recorded, or was generic such as "alert, and oriented" without a specific description of the behavior included to support the generic documentation. Providing a specific description of the individual that reflects their mental status such as "yelling at staff with fists clenched" clearly reflects the mental status of the individual rather than using generic statements. From discussions with the Chief Nurse Executive, the QA Nurse, and Program Compliance Nurse, since the last review, the Facility's Nursing Department had not yet established a formal system to review and analyze these data or address the problematic issues found. The same was true for the data related to Section C.6 addressing the documentation of assessment by a licensed health care professional to determine whether there were any restraint-related injuries or other negative health effects. Based on documentation provided by the Facility, three restraints had occurred off the grounds of the Facility in the last six months. A sample of three was reviewed (Sample #C.5). A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in three out of three (100%). ▪ n. Monitored and documented vital signs in three (100%). ▪ o. Monitored and documented mental status in none (0%), based on the generic entries on the form (alert, oriented, ambulatory) rather than a description of the behavior as described in C.4.j above. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In none out of four (0%), the physician specified the schedule of monitoring required or specified that Facility policy regarding this was to be followed. In the Presentation Book, a form was provided that specified a routine for monitoring of a medical restraint. That form was not included in any of the four records reviewed (i.e., MHRS 2.1 revised 5/05.) ▪ q. In none of the records had the physician specified a type of monitoring. However, the type of monitoring was specified on the forms being used. ▪ r. In one out of four of the medical restraints (25%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. That one was for Sample #C.3.4. In Sample #C.3.1, there was no monitoring recorded for an hour and forty minutes after the	

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		medication was given and before the appointment for treatment. In Sample #C.3.2, there was no post-treatment monitoring, and in Sample #C.3.3, the medication was administered one hour before the appointment instead of one-half hour before as prescribed by the physician, and there was only one instead of two 30-minute monitorings post-sedation. Based on this review the Facility is not in substantial compliance because the medical restraints were not being written to specify or reference a schedule of monitoring, and monitoring was not always conducted according to the guidelines available. In addition, the monitoring of restraints by licensed medical professionals was not being completed timely, and was not of adequate quality.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 30 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In 29 (97%), continuous one-to-one supervision was provided. Enhanced supervision was provided in Sample # C.1.1; ▪ b. In 30 (100%), the date and time restraint was begun; ▪ c. In 30 (100%), the location of the restraint; ▪ d. In 28 (93%), information about what was happening prior to the change in the behavior that led to the use of restraint. In Sample #C.1.1 and Sample #C.1.5, there was no information about what was happening prior to the change in behavior. ▪ e. In 29 (97%), the actions taken by staff prior to the use of restraint to permit adequate review per Section C.8. In Sample # C.1.14, the Debriefing form indicated that de-escalation actions had not been documented. ▪ f. In 30 (100%), the specific reasons for the use of the restraint ▪ g. In 30 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 30 (100%), the names of staff involved in the restraint episode; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 29 (97%), the observations documented every 15 minutes and at release. The one that did not was Sample #C.1.7, where the individual was held for 29 minutes without attempt to release, and without observations documented every 15 minutes. The six in chemical restraint were observed every 15 minutes for at least two hours. o j. In 23 of 24 physical restraints (96%) the behaviors that required continuing restraint were recorded. One restraint lasted more than 15 minutes, and the specific behaviors of the individual that required continuing restraint were not recorded. This was Sample #C.1.7; and	Noncompliance

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		o k. In 24 of 24 physical restraints (100%), the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. ▪ l. In 24 of 24 physical restraints (100%), the level of supervision provided during the restraint episode; and ▪ m. In 24 of 24 physical restraints (100%), the date and time the individual was released from restraint. Based on a review of 28 restraint records for 22 individuals for restraints that occurred at the Facility (i.e., Individual #284, Individual #51, Individual #213, Individual #288, Individual #46, Individual #27, Individual #320, Individual #131, Individual #64, Individual #124, Individual #61, Individual #239, Individual #240, Individual #154, Individual #155, Individual #40, Individual #38, Individual #279, Individual #251, Individual #4, Individual #57, and Individual #36): ▪ n. In 27 (96%), 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 #251 on 4/15/13 at 10:01 a.m. The problematic issue that resulted in noncompliance included the injury section being left blank. o. In a sample of 30 records (Sample #C.1), restraint-debriefing forms had been completed for 30 (100%). p. A sample of four individuals subject to medical restraint was reviewed (Sample #C.3), and in one (25%), there was evidence that the monitoring had been completed as required by the physician's order, as discussed above with regard to Section C.4. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last on-site review. This sample of six individuals who were the subject of a chemical restraint was reviewed: q. In six (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review the Facility's efforts to improve documentation of restraint use were evident. The areas where additional attention was needed were: 1) to the documentation of the physician's order for medical restraints, including the schedule and	

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		type of monitoring; and 2) the documentation of the monitoring by the licensed health care professional to match the physician's order or the standard monitoring as delineated on the monitoring form. The Facility's Self-Assessment noted the issue with the physician's orders and included an action step to address. The Facility was not in noncompliance with this provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to documentation identifying individuals restrained between November 2012 and May 2013, 11 individuals were placed in physical restraint more than three times in any rolling 30-day period. Of these 11 individuals, a sample of four individuals (reflecting a sample of 36%), with more than three restraints in any rolling 30-day period, between November 2012 and May 2013, was selected for review to determine if the requirements of the Settlement Agreement were met. For each individual selected, four consecutive restraints that occurred within a 30-day rolling period were reviewed. Identified individuals as well as specific dates and times are detailed above in the "Review of Following Documents" section (i.e., Sample #C.6). 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, Individual Support Plans, 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. a. For two individuals (50%), there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. The following are examples of where this did occur: o Individual Support Plan Addendums (ISPAs) dated 3/21/13 and 4/17/13 indicated that the IDT for Individual #131 met and discussed the four restraints that occurred on 3/18/13, 3/20/13, and 3/21/13 as well as 4/6/13, respectively. The ISPA template designed to facilitate adequate team review (following more than three restraints in any rolling 30-day period) appeared to be completed for both meetings (see below for specific details).	Noncompliance

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		o An ISPA, dated 3/13/13, indicated that the IDT for Individual #64 met and discussed the four restraints that occurred on 2/14/13, 2/20/13, and 3/4/13 (multiple restraints). The ISPA template designed to facilitate adequate team reviewed (following more than three restraints in any rolling 30-day period) appeared to be completed. The following are examples of where the team failed to adequately meet to discuss the specific restraints as identified: o The IDT for Individual #46 did meet following the more than three restraints in a rolling 30-day period specifically identified above. However, the provided ISPA only evidenced that the IDT discussed one of the four restraints sampled for review. That is, the ISPA (dated 5/14/13) evidenced an IDT meeting held to discuss four restraints that occurred on 3/24/13, 3/26/13, and 3/39/13. Consequently, only one of the restraints currently sampled (dated 3/29/13) was reviewed by the IDT. It was unclear to the Monitoring Team why the subsequent restraints reported in April 2013 (and sampled here) were not reviewed at this meeting - especially given that the IDT meeting, as evidenced by the ISPA, occurred on 5/14/13. Overall, it was very challenging for the Monitoring Team to determine the nature of IDT review for the sampled restraints as well as all the restraints recorded for Individual #46 over the past six months. That is, noted inconsistencies across provided documentation as well as the timing of reviews led the Monitoring Team to question the adequacy of the IDT review. For example, summary data collected by the Facility to track the completion of ISPAs for more than three restraints in a 30-day period (i.e., "Restraints Used by QDDP Department to Track ISPAs") was inconsistent with regard to the number of restraints listed for Individual #46 when compared to the actual number reported in corresponding ISPAs (i.e., ISPAs for 2/25/13 and 5/24/13). In addition, the order in which restraints were reviewed, relative to when they occurred, appeared confusing. More specifically, restraints that occurred the last week of March were reviewed on 5/14/13, while restraints that occurred earlier in March (the first two weeks) were reviewed on 5/24/13. In addition, although several other IDT meetings (to discuss restraint) were held throughout March (i.e., ISPA dated 3/4/13, 3/5/13, 3/15/13, and 3/25/13), the restraints reviewed were not specifically identified and the required ISPA format (i.e., to be used for more than three restraints in any 30-day rolling period) was not utilized. Consequently, although additional meetings were held, they appeared to reflect inadequate review by the IDT. Lastly, although the required ISPA format was used for three of the meetings as noted above (i.e., dated 2/25/13, 5/14/13, and 5/24/13), all three meeting minutes were not filed (based on the stamped filed date) until 6/7/13. It was unclear to the Monitoring Team why only those meetings	

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		minutes utilizing the required ISPA format were filed late and on the same day. Overall, it appeared that IDT review of selected restraints as well as other restraints (over the past six months) for Individual #46 appeared disorganized, inadequate, and late (i.e., in some cases over two months from when the restraints occurred). o The IDT for Individual #51 did meet following the more than three restraints in a rolling 30-day period (ISPA dated 7/1/13) as sampled and specifically identified above. However, the meeting was held more than three months after the first restraint was completed (on 3/22/13). Although the IDT did not meet in a timely fashion, the team appeared to utilize the ISPA template designed to facilitate adequate team review (following more than three restraints in any rolling 30-day period). Based on the above findings, the subsequent review included the examination of only those ISPAs completed on all of the restraints sampled in a timely manner. Consequently, the ISPAs and other documentation (i.e., positive behavior support plans, crisis intervention restraint plans) were reviewed for two selected individuals (i.e., Individual #131, and Individual #64) and the findings are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. b. Of the two individuals reviewed, one (50%) of individuals' teams (as reflected in ISPAs) discussed each individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables impacting the individual's behavior. o ISPA documentation, dated 3/21/13 and 4/17/13, for Individual #131 evidenced that the IDT discussed his communication and social skills. In addition, they discussed potential strategies to address better support his effective communication and social interactions, including journal and note writing, use of a social story and involvement in counseling. The discussion would have been more effective if more comprehensive data was presented (i.e., regarding his use of these interventions) as well as if the IDT had made recommendations more focused on revising current skill programming (related to replacement behaviors) as appropriate. ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced that the IDT discussed biological and medical factors that could contribute to behaviors that led to restraint. For example, his psychiatric, intellectual diagnoses, and medical disorders were discussed. In addition, ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced that the IDT discussed psychosocial factors that could contribute to behaviors that led to restraint. For example, his history of sexual abuse was discussed in light of his upcoming community placement and recent restraints.	

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		o As discussed below, Individual #64's team did not address his adaptive skills appropriately. However, the ISPA, dated 3/13/13, for Individual #64 evidenced that the IDT discussed the role of biological and/or medical factors in contributing to behaviors that led to restraint. For example, the IDT discussed underling psychiatric and intellectual diagnoses and their potential influences on behavioral responding. The ISPA, dated 3/13/13, for Individual #64 also 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, including his history of abuse and neglect, and potential current implications. The following are examples of where teams failed to do this adequately: o ISPA documentation, dated 3/13/13, for Individual #64 indicated that "[Individual] has many skills and has learned appropriate social behavior" and, when he uses sexually suggestive language and is redirected, becomes "angry and defensive." This description suggests a discussion of the contingencies around the target behavior but not the necessarily an examination of the individual's adaptive skills. Overall, the IDT did not appear to actively discuss the alternative behavior listed in the PBSP (i.e., socially appropriate behavior) and how this behavior may or may not help ameliorate the responses that led to his restraint. Indeed, no data appeared to be presented or discussed in relation to this behavior. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in <u>two</u> of the cases (100%). Of these, there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint in none of the cases (0%), as discussed above. The Facility remained out of compliance with this provision.	
	(b) review possibly contributing environmental conditions;	a. 50% of the cases had documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. b. Of the two individuals reviewed, two (100%) of individual's teams (as reflected in ISPAs) that discussed the possibly contributing environmental conditions, including: o ISPA documentation, dated 3/21/13 and 4/17/13, for Individual #131 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 upcoming changes in the living situation as well as the pattern of restraints as related to his routines and work schedule. o The ISPA, dated 3/13/13, for Individual #64 evidenced that the IDT discussed potential environmental factors that might have contributed to behaviors that	Noncompliance

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		led to restraint. For example, the IDT hypothesized that his recent move to the Facility, including new staff and routines, as well as being far from his family, for example, might have contributed to his aggressive behavior. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two of the cases (100%). • The IDT for Individual #131 identified a potential move to the community as a potential source of agitation leading to restraint, and subsequently rescinded the referral to the community. • The ISPA, 3/13/13, for Individual #64 evidenced that the IDT discussed the development of a new SFBA, PBSP and CIP to address issues related to environmental conditions related to the behaviors that lead to restraint The Facility remained out of compliance with this provision.	
	(c) review or perform structural assessments of the behavior provoking restraints;	a. 50% of the cases had documentation of an ISPA following each episode of an individual having more than three restraints in a rolling 30 days. b. 100% of these ISPAs reflected a discussion of potential environmental antecedents to the behaviors that provoke restraint, including: c. ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced that the IDT examined each restraint, attempted to identify precursors of each restraint as well as any common elements. It appeared that the team attempted to identify any potential triggers to the behaviors that led to restraint. d. The ISPA, dated 3/13/13, for Individual #64 indicated that the IDT examined each restraint and attempted to find commonality. In addition, the IDT discussed the status of the new SFAR and the revised PBSP. e. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two of the cases (100%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two of the cases (100%). o The ISPA, dated 3/31/13 and 4/17/13, for Individual #131 evidenced IDT recommendations for the use of counseling supports. o The ISPA, 3/13/13, for Individual #64 evidenced that the IDT discussed the development of a new SFBA, PBSP and CIP to address issues related to the environmental triggers related to behaviors that lead to restraint. The Facility remained out of compliance with this provision.	Noncompliance
	(d) review or perform functional	a. 50% of the cases had documentation of an ISPA following each episode of an	Noncompliance

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	assessments of the behavior provoking restraints;	individual having more than three restraints in a rolling 30 days. b. 100% of ISPAs that reflect a discussion of the variable or variables that potentially are maintaining the behavior provoking restraints, including: o ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced that the IDT attempted to examine the contingencies involved in the target behavior (aggression) that necessitated restraint. This included closely reviewing the consequences of the restraint as well as potential social outcomes associated with these occurrences. o The ISPA, dated 3/13/13, for Individual #64 indicated that the IDT appeared to examine the contingencies associated with the restraints, including the observed consequences as well as their potential underlying functions. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in one of the cases (50%). Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in one of the cases (100%). o The ISPA, 3/13/13, for Individual #64 evidenced that the IDT discussed the development of a new SFBA, PBSP, and CIP to address issues related to the underlying functions of behaviors that led to restraint The Facility remained out of compliance with this provision.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use	a. Of the two individuals for whom teams had met timely, two (100%) individuals had a current PBSP at the time of the restraints. Of the two individuals, zero (0%) individuals had a Crisis Intervention Restraint Plan (CIRP) in place at the time of the selected restraints. However, it appeared that CIRPs were subsequently developed and currently in place for the two (100%) individuals for whom teams had met timely. b. 100% of PBSPs reviewed that had operationally defined target behaviors. c. 50% of PBSPs reviewed contained functional replacement behaviors (when practical and possible): o That is, the PBSP for Individual #131 formally identified and defined journal writing as well as targeted other more informal strategies (walking, etc.) used to teach more positive and adaptive behavior in place of the behavior that initiated restraint. The exception included the PBSP for Individual #64 that did not include a specific replacement based on a SFAR (was not completed at the time). An alternative behavior (socially appropriate behavior) was identified, but this appeared to be poorly defined and an inadequate adaptive response in relation to his significant aggression directed at peers and staff. d. 100% of PBSPs reviewed that specified, as appropriate, the use of other programs to	Noncompliance

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	of the restraint shall be set out in the individual's ISP;	reduce or eliminate the use of restraint. e. Two (100%)% of PBSPs reviewed that contain interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment. More specifically, they specified, as appropriate, the use of procedures (i.e., antecedent and/or consequence based strategies) to reduce or eliminate the use of such restraint. It should be noted, however, that the interim PBSP for Individual #64 included strategies that appeared somewhat limited. f. Two (100%) of crisis intervention plans delineated the type of restraint authorized. g. Two (100%) of crisis intervention plans specified the maximum duration of restraint authorized. h. Two (100%) of crisis intervention plans specified the designated approved restraint situation. i. Two (100%) of crisis intervention plans specified the criteria for terminating the use of the restraint. The Facility remained out of compliance with this provision.	
	(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	a. One (50%) case had presence of treatment integrity data for each individual having more than three restraints in a rolling 30 days: o ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced that the IDT examined treatment integrity of the PBSP (competency-integrity checks) as well as the reliability of the data collected (inter-observer agreement). More specifically, the ISPA reported when these were completed and provided examples of estimated level of integrity and agreement. o The ISPA, dated 3/13/13, for Individual #64 did not evidence discussion of treatment integrity data related to the PBSP or collection of IOA data b. 50% (i.e., amount) of the individuals' treatment plans were implemented with at least 80% treatment integrity The Facility remained out of compliance with this provision.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	a. In three (75%) of four cases, there was presence of a review of the PBSP in the ISPA for individuals having more than three restraints in a rolling 30 days. As noted above, for the remaining individual, the team did not meet to discuss the sampled restraints. b. Of these individuals, the ISPA indicated that a revision was necessary in <u>none</u> of the cases. As a result, there was no need for review of evidence of a revision to the PBSP. o ISPA documentation, dated 3/31/13 and 4/17/13, for Individual #131 evidenced discussion of the PBSP and recommendations of the IDT to not	Noncompliance

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		make significant changes at that time. o The ISPA, dated 3/13/13, for Individual #64 indicated that the IDT discussed the current interim PBSP and the upcoming completion of the SFAR. The IDT indicated that, once completed, the SFAR would likely significantly inform the next revision of the PBSP. o Although the team met late, the ISPA, dated 7/1/13, for Individual #51 indicated that the IDT discussed the current PBSP and indicated that, once the revision to the SFAR was completed, the PBSP would be revised. The Facility remained out of compliance with this provision.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	A sample of documentation related to 30 incidents of crisis intervention restraint was reviewed (Sample #C.1), including [Unit Team meeting and IMRT meeting minutes, Restraint Reduction Committee minutes as incorporated into QAQI Council minutes, and ISPAs. This documentation showed that: ▪ a. In 30 (100%), the review by the Unit IDT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. ▪ b. In 30 (100%), the review by the IMRT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. ▪ c. In 28 (93%), the circumstances under which the restraint was used was determined and was documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. One record where this was not the case was Sample #C.14 in which it was not clear whether the actions taken prior to the restraint included efforts to de-escalate the behavior. The Restraint Checklist documented use of PMAB skills and prompting of replacement behaviors and the Face-to-face checked that a graduated range of less restrictive measures was employed. However the debriefing sheet indicated no "de-escalation techniques documented" making it unclear whether there had been attempts at alternatives to restraint or whether none could be attempted due to the nature of the behavior. As a result the determination of the circumstances was incomplete. The second was Sample #C.1.5 in which there was no information about what was happening prior to the change in behavior. ▪ d. In 25 of 30 (83%), the review conducted by the Unit IDT and the IMRT 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	Noncompliance

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		emergency nature of the behavior that resulted in restraint. The IMRT minutes included a section where basic information about the restraint was collected (e.g., time, type, trigger, dangerous behaviors, etc.) and a section with more narrative description of the need for the restraint, the type of restrictive practice, and a space for the date of any IDT meeting. Comments from the IMRT were generally sparse with little attention given to prevention or what might be learned that could apply to others in the system. In the following records, something was missing that the IMRT did not identify: o In Sample #C.1.5 the form that was provided to IMRT for review did not include an indication of the triggers and precursors to the restraint and the minutes did not inquire into those factors. o In Sample #C.1.7, there was no attempt to release the restraint at 15 minutes as required by policy, and no explanation was provided as to why this was not done. Neither the Face-to-face nor the debriefing sheets included an explanation, and the IMRT did not inquire as to why the policy was not followed. o In Sample #C.1.12, the minutes of the IMRT did not match the restraint documentation. o In Sample #C.1.14, the circumstances of the restraint were not sufficient to allow analysis as described in C.8.c above. o For Sample #C.1.26, there were no IMRT minutes provided. ▪ e. In 22 of 30 (73%), referrals were made to the team, as appropriate: o In Sample #C.1.1, the IMRT did not refer to the team, but the team met anyways. It was not clear if the IMRT knew that was going to happen and thus made no referral, or if the IMRT did not think a team meeting was necessary. o In Sample #C.1.8, the IMRT minutes indicated that the individual had had nine restraints within a three-hour period when the individual wanted food that was not on his diet. The IMRT did not order follow-up by the IDT in spite of the fact that restraints in excess of three in 30 days require follow-up under policy. o In Sample #C.1.5, the IMRT did refer, but a note in the record indicated that the IDT did not follow up, and the IMRT's follow-up to this was unclear; o In Samples #C1.15, C.1.16, and C.1.17, there were three restraints on the same day in close succession and the IMRT noted a fourth, yet there was no indication of a need for IDT follow-up and no explanation as to why not. o In Sample #C.1.21 the IMRT did not order follow-up by the IDT even though the Debriefing sheet recommended a review of the individual's	

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		reinforcement schedule as a possible method to prevent future incidents requiring restraint. However, the IDT did meet and make adjustments to his program. o In Sample #C.1.28, the restraint was preceded by issues around use of tobacco. The IMRT did not comment or give directions to further explore the issue (although the IDT did do that.) It is possible that the IMRT knew that some of these issues would be automatically referred to the IDTs, and therefore, did not find it necessary to reiterate the need to do that. Even if that were the case, endorsing that expectation in the minutes would assure that it happened, and that the results would be shared with the IMRT since those results might have implications for prevention of future restraints with the individual or with other individuals. ▪ f. Of the one referred to the team, no appropriate changes (0%) were made to the individuals' ISPs and/or PBSPs. The one was Sample #C.1.9 where the referral box in the IMRT minutes was checked, but no team meeting was held. Although not related to compliance with Section C (but relevant to Section E), the Restraint Reduction Committee had been combined with the QAQI Council and presentations were captured in the Council minutes. The presentations included trend charts with analyses, and data on restraints by individual. However, there was little documentation of discussion of either the trends or the individual restraints. Nor did corrective action plans emerge from the review of the data. For example, the Director of Behavioral Services reported in February that homes #514 and #516 appeared to be where the most issues were and where focus needed to be applied. In March 2013, the restraint reporting expanded with the addition of reports showing restraints by individual with a log of the attempts to avoid the restraint; staff involved in restraints and other breakdowns of data that could be useful in determining how and where to focus reduction efforts. However, there was no reported discussion of such data by Council members in the Council minutes. The QAQI Council meeting attended during the site visit, included cross-disciplinary discussion of presented data, so it was not clear whether minutes did not capture discussion or whether no discussion took place. The key elements of discussions should be captured in the minutes to form a history of efforts to promote positive change. Based on this review the Facility was not in substantial compliance with the requirements of the Settlement Agreement. The Facility Self-Assessment found the same.	

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: Reassigning Staff due to ANE, revised 3/7/12; o LBSSLC – Incident Management: Abuse, Neglect or Exploitation, revised 2/19/13; o LBSSLC Policy: Incident Management: Observation Note Audit Procedure, dated 4/11/13; o LBSSLC Policy: Campus Coordinator/Administrator Log Procedure, dated 6/19/12; o State Supported Living Center Procedure: Injury Audits, dated March 2013; o Sample #D.1 included a sample of 15 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related as listed in the following table:

Sample Identification #	DFPS #	Facility #	Date
1	42574222	13-045	12/11/12
2	42585553	13-050	12/17/12
3	42602396	13-059	12/28/12
4	42617654	13-068	1/11/13
5	42628798	13-073	1/20/13
6	42631965	13-077	1/23/13
7	N/A*	13-086	2/7/13
8	42657627	13-085	2/17/13
9	42675908	13-097	3/6/13
10	42686863	13-106	3/20/13
11	42701829	13-114	4/4/13
12	42714927	13-122	4/16/13
13	42718872	13-126	4/18/13
14	42742804	13-136	5/11/13
15	42754230	13-145	5/11/13

* This was returned to the Facility by DFPS as an information and referral without assignment of a case number.

o Sample #D.2 included a sample of nine investigation reports completed by the Facility only as listed in the following table:

Sample Identification #	Facility Investigation #	Date
1	13-055	12/23/12
2	13-062	1/2/13
3	13-074	1/21/13
4	13-084	2/12/13

5	13-093	3/2/13
6	13-101	3/17/13
7	13-113	3/29/13
8	13-130	4/30/13
9	13-137	5/12/13

- Sample #D.3: no additional reports were selected for review at the on-site visit;
- Sample #D.4: Individual Support Plans (ISPs) for Individual #61, Individual #68, Individual #168, Individual #242, and Individual #273;
- Sample #D.5: A subsample of the investigations listed in Samples #D.1 and #D.2:

Sample Identification #	Facility Investigation #
D.1.8	13-085
D.1.12	13-122
D.2.3	13-074
D.2.4	13-084
D.2.7	13-113

- Sample #D.6: Observation Note Audits for Individual #323 (review range: 11/1/12 to 4/30/13), Individual #27 (review range: 11/1/12 to 4/30/13), Individual #235 (review range: 1/1/13 to 6/30/13), and Individual #136 (review range: 11/1/12 to 4/30/13);
- Incident Management Review Team (IMRT) meeting minutes for each Monday in March and April 2013;
- LBSSLC Executive Safety Committee (Addressing November 2012 through April 2013), 5/22/13;
- LBSSLC Executive Safety Committee (Addressing October 2012 through March 2013), 3/27/13;
- LBSSLC Executive Safety Committee (Addressing September 2012 through February 2013);
- List of Individuals (one) for Whom Adult Protective Services Conducts "Streamlined Investigations;"
- Background check spreadsheets;
- Rights Poster;
- Training records/transcripts for Facility investigators;
- Training records/transcripts for DFPS investigators;
- Statements acknowledging reporting obligations signed by 24 employees;
- Training transcripts for 24 employees regarding training on the reporting of abuse, neglect, and exploitation;
- Presentation Book for Section D;
- Minutes of Quality Assurance/Quality Improvement Council meetings, dated from 3/21/13 through 5/14/13;
- For the last year, lists of injuries by individual, living area, and by type; and

- Trend Analysis Reports for the Executive Safety Committee, dated 5/22/13.

- **Interviews with**:
  - Libby Allen, Facility Director;
  - Robin Seale, Assistant Director of Programs;
  - Rodney McWilliams, Incident Management Coordinator;
  - Jim Forbes, M.Ed, BCBA, Director of Behavioral Services;
  - Dawn Ripley, Director of Quality Assurance;
  - Interviews with 10 staff concerning their knowledge of basic incident management rules; and
  - Interviews or observations of 10 individuals regarding their ability to report abuse or neglect.
- **Observations of**:
  - Visits to nine residences (i.e., 513, 514, 515, 516, 517, 518, 523, 525, and 526), and the workshop;
  - Incident Management Review Team Meeting, on 7/10/13;
  - Executive Safety Committee meeting, on 7/11/13;
  - Quality Assurance/Quality Improvement Committee meeting, on 10/3/12;
  - Self-Advocacy meeting, on 7/9/13; and
  - Unit I and II morning meeting, on 7/10/13.

Facility Self-Assessment: The Lubbock State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance with 21 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 20 of the 22. The differences appear in the following table:

Provision	Facility Self-Assessment	Monitoring Team Finding
D.2.a	Noncompliance	Substantial compliance
D.2.i	Substantial compliance	Noncompliant
D.4	Substantial compliance	Noncompliant

In its Self-Assessment, dated 6/20/13, 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.

Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, and interviews with staff:

- 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 month and applied this tool.
- 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. ▪ The monitoring tools included some adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed. The monitoring tool guidelines indicated that review might include interviews, observations and other relevant information, yet there was little indication that such methods were employed. ▪ The Self-Assessment identified the sample sizes, including the number of investigations reviewed in comparison with the total number of investigations conducted in the month. A random sample of four investigation files was selected for review each month, irrespective of the number of investigations conducted. This resulted in an average of over 20% (28 of 114 investigations between November 2012 and May 2013), which was an adequate sample. ▪ The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, it was not clear that there was inter-rater reliability established on all questions of the tool. ▪ The Quality Assurance Program Compliance Monitor (PCM) worked with the Incident Management Coordinator to complete the audit tools. ▪ 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). ▪ Information on inter rater reliability was provided in the Self-Assessment, but only in general terms. The samples were noted as for March 2013 "20% sample with inter rater reliability of 93.6%". The more important question would be what the inter rater reliability was on the specific questions in the monitoring tool that were used to gauge compliance. ▪ In addition to data from the audits of investigation files, the Facility cited other data in its Self-Assessment. For example, it used data from the Competency and Training Department database on abuse, neglect, and exploitation training, and collected data on all investigations for some questions (e.g., all investigations for April and May 2013 were examined to determine if reporting deadlines were met). However, the Facility did not present data on key indicators or outcome measures in its Self-Assessment, since key indicators had only been adopted in June 2013. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically: o Many of the findings were presented as specific, measurable indicators. Some indicators were missing because the Facility had chosen to focus on indicators that had been found out of compliance. For example, Section D.3.e had at least six separate indicators for compliance, including recommendations for corrective action. The Facility elected not to focus on whether a report was written and included a summary and findings, and the report was understandable, since files had included these elements for some time. However, the inclusion of recommendations was an indicator that might have benefited from additional focus and was excluded as well. ▪ The Action Plans that accompanied the Facility Self-Assessment included steps to improve in provisions not found to be in compliance as well as maintenance steps to assure continued compliance with those provisions where there was substantial compliance. The maintenance steps provided a good method for assuring that compliance would be continuously monitored and

	reviewed.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 20 out of 22 provisions of Section D, as opposed to 13 provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ The Executive Safety Committee demonstrated the process and the potential of a key component of a sustainable system, that is a process for examining data for trends. This process should net more of the needed actions and action plans as the Facility progresses. ▪ Brochures and information about reporting abuse were being provided to Legally Authorized Representatives (LARs) and individuals in annual meetings, and documented in the ISPs reviewed and in the meetings the team attended. ▪ The process for auditing injuries looked promising. While the system was new, and a full semi-annual audit had not yet been completed using the new process, there was decided progress. Some of the areas in which improvements were necessary for the Facility to progress toward compliance with the Settlement Agreement included the need to: ▪ Document responses to system issues and complex individual issues that are identified through data analysis. This can be done in several ways: o Use the CAP system to formulate responses, particularly when multiple disciplines are needed to resolve the issue; o Formulate action plans where one discipline is involved in a systemic issues; o Use Individual Support Plan Addenda (ISPAs) to address individual issues that are identified through data analysis and link the resolution of such issues to the minutes of Executive Safety Committee or QAQI Council minutes. ▪ Conduct the injury audit process to assure that the Facility identifies clusters of injuries or patterns of injuries that need investigation; and ▪ Ensure DFPS investigations include applicable recommendations. At the time of the most recent review, the Unusual Incident Report (UIR) did include them, but the long-term integrity of the process relies on DFPS to be making recommendations or registering concerns.

#	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.	The Facility's policies and procedures: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result, this provision was found to be in substantial compliance. The Facility found the same in their Self-Assessment.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D2</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

According to data the Facility provided in response to request TX-LB-1307.TR.1 the numbers of abuse/neglect/exploitation allegations for the past year were:

<table><tr><th></th><th>6/1/12 to 11/30/12 (Six months)</th><th>12/1/12 to 5/31/13 (Six months)</th></tr><tr><td>Total abuse allegations</td><td>20</td><td>50</td></tr><tr><td>Abuse substantiated</td><td>7</td><td>8</td></tr><tr><td>Total neglect allegations</td><td>69</td><td>47</td></tr><tr><td>Neglect substantiated</td><td>14</td><td>5</td></tr><tr><td>Total exploitation allegations</td><td>1</td><td>1</td></tr><tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr></table>
According to Facility data provided in response to request TX-LB-1307.TR.1 the numbers of Unusual Incidents investigated over the past two years included:

<table><tr><th></th><th>6/1/12 to 11/30/12 (Six months)</th><th>12/1/12 to 5/31/13 (Six months)</th></tr></table></td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Deaths	0	3
Serious Injuries	14	14
Sexual Incidents	4	6
Suicide Threat (credible)	2	2
Unauthorized Departure	11	16
Choking	2	2
Other	2	5

Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

Metric 2.a.2: According to LBSSLC – Incident Management: Abuse, Neglect or Exploitation, dated 2/19/13, staff were required to report abuse, neglect, and exploitation within one hour by phone call to DFPS and to the Facility Director. This was consistent with the Settlement Agreement requirements.

Metric 2.a.3: With regard to unusual/serious incidents, the Facility policy entitled LBSSLC – Incident Management: Abuse, Neglect or Exploitation, dated 2/19/13, required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to call the Director or Designee. This policy was consistent with the Settlement Agreement requirements.

*Metric 2.a.4: Based on responses to questions about reporting, nine of 10 (90%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

*Metric 2.a.5: Based on responses to questions about reporting, nine of 10 (90%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents.

Based on a review of the 15 investigation reports included in Sample #D.1:

- Metric 2.a.6: 14 (93%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. The one case that did not was Sample #D.1.13 where a staff member held a door shut to prevent an individual from exiting, resulting in a finding of confirmed physical abuse. Two other staff were present, yet the allegation was not reported until the next day.

#	Provision	Assessment of Status	Compliance
		▪ Metric 2.a.7: 15 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.8: For the one allegation for which staff did not follow the Incident Management (IM) Policy and Reporting Matrix reporting procedures, (Sample #D.1.13) the UIR/investigation folder (100%) included recommendations for corrective actions. Based on a review of nine investigation reports included in Sample #D.2: ▪ Metric 2.a.9: Eight (89%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. The one that was not, Sample #D.2.4 was an injury that was determined to be a fracture at 10:35 a.m., but not reported as a serious injury until 3:10 p.m. ▪ Metric 2.a.10: Nine (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.11: For the one unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folder included recommendations for corrective actions. Metric 2.a.12: The Facility had a standardized reporting format. Metric 2.a.13: Based on a review of 24 investigation reports included in Samples #D.1 and #D.2, 24 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Based on the metrics, there was one that scored 89%, but it involved one unusual incident, and it was followed up with appropriate corrective action per the UIR. As a result, the Facility was found to be in substantial compliance with this provision. The Facility Self-Assessment did not find substantial compliance because in only 89.7% of the Facility sample were the reporting timelines met.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with	According to LBSSLC – Incident Management: Abuse, Neglect or Exploitation, dated 2/20/13, the Facility was to take immediate steps to stop the abuse, arrange for nursing or medical examination, comfort and reassure the victim, preserve and secure physical evidence, and place the alleged perpetrator on temporary work reassignment, out of contact with individuals. Based on a review of 15 investigation reports included in Sample #D.1, in 15 (100%) the alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 15 investigation files included in Sample #D.1, a total of 15 (100%) showed that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation. Based on a review of 15 of the above documents, it was documented that adequate additional action was taken to protect individuals in 15 cases (100%). For example, individuals were provided with assessments of their emotional health, physical assessments to determine if there were injuries, increased staffing, or increased monitoring as appropriate to the individual situation. In the nine cases reviewed in Sample #D.2, staff were not removed from duty, since there were no allegations of abuse or neglect. If there had been, the cases would have been referred to DFPS. The Facility was found to be in substantial compliance based on the consistent removal of alleged perpetrators from direct contact with individuals pending the outcome of investigation, as well as the Facility's additional actions to protect individuals. The Facility found the same in their Self-Assessment.	
	(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 was to 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 conducted 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 curriculum provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 24 staff records (Sample #C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect prior to working directly with individuals.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on interviews with 10 staff: ▪ 10 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ 10 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. As a result of these findings, the Facility remained in substantial compliance with this provision. The Facility found the same.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	As described in earlier reports, the Facility's policy and practice required that all employees sign a statement confirming the obligation to report abuse, neglect, and exploitation. The statement was first signed at new employee orientation and, then, annually thereafter. A sample of 24 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 24, 24 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of two staff. Personnel actions related to these failures were reviewed, which revealed the following: ▪ A staff member who failed to report an allegation of physical abuse – level II was no longer working at the Facility; ▪ A staff member who failed to report timely an allegation of physical abuse – level II was placed on a second level reminder, which included a letter in the personnel file. All 10 employees queried informally about this obligation were able to describe their responsibility. The Facility remained in substantial compliance with this provision, and the Facility found the same in its Self-Assessment.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide	As in earlier reports, a review was conducted of the materials used to educate Legally Authorized Representatives, 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of five individuals' ISPs (Sample #D.4), five individuals, or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. In interviewing a sample of 10 individuals, five were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. The remaining five did not have sufficient communication skills to respond to questions. The Facility provided a list of 14 incidents that were known to have been reported by seven individuals. A review was conducted of one of those incidents (UIR 13-122), and there was evidence Facility staff provided adequate support to the reporter. 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. Individuals were known to be reporting incidents of abuse and neglect. As a result the Facility was found to be in substantial compliance with this provision. The Facility's finding was the same.	
	(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. Observations by the Monitoring Team of ten residences and day programs on campus showed that all (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Facility remained in compliance with this provision and the Facility Self-Assessment found the same.	Substantial Compliance
	(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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on a review of 15 allegation investigations completed by DFPS (Sample #D.1), in 11 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 11 (100%). Based on a review of nine investigations completed by the Facility (Sample #D.2), the Facility had not made referrals in any case. None of these cases required referral to law enforcement. Generally when a case required referral to law enforcement, it was also referred to DFPS for investigation for possible abuse or neglect. Since allegations that needed to be reported to law enforcement were reported, the Facility continued to be in substantial compliance. The Facility Self-Assessment found the same.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	As indicated in the last report, according to LBSSLC's policy "Incident Management: Abuse, Neglect or Exploitation," retaliation against a person for reporting abuse, neglect, or exploitation was prohibited. Any person who believed he or she was being subjected to retaliatory action upon reporting an allegation, or who believed an allegation had been ignored, was directed to immediately, within one hour, contact the Director or her designee. The Office of the Attorney General, the Office of the Inspector General, and DFPS also could be contacted. The Whistleblower Act, Texas Civil Statutes, Article 6252-16a, permitted prosecution of a supervisor who suspended, or terminated a public employee for reporting a violation of law to a law enforcement authority. Any employee or agent found to have engaged in retaliatory action was subject to disciplinary action. Based on interviews with the Facility Director, the ADOP and the Incident Management Coordinator the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ Posters were displayed indicating zero tolerance for retaliation; ▪ Retaliation was discussed in training on reporting abuse and neglect; and ▪ The OIG had provided a class on retaliation. Based on interviews with 10 staff, nine (90%) reported they were confident that retaliation would not be tolerated. The one staff member who voiced concern indicated he would report abuse anyways. Based on interviews and observation with 10 individuals served by the Facility, five of the five (100%) with sufficient communication skills reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		one concern noted related to potential retaliation. However, the alleged retaliation was not for good faith reporting of abuse or neglect. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation and no names of staff were on the list. The Facility remained in substantial compliance with this provision. The Facility's finding was the same.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The Facility policy and/or procedures did not define sufficient procedures to audit whether significant injuries are reported for investigation. While the procedures specified who would conduct the audits, what documents would be audited, and how discovered discrepancies would be reported, the following problems were noted: ▪ The method for drawing the sample was not specified. The State Office-issued procedure indicated the sample could be random or focused, but gave no other indication of method. The Facility procedure, Observation Note Audit Procedure, did not specify a sampling method either. ▪ It was not clear how data on injuries would be used to identify trends or clusters of injuries that might be suspicious and in need of investigation. This should include for example, incidents for specific individuals or residences, as well as identification of peer-to-peer aggression resulting in injuries that requires investigation. On February 15, 2013, the Monitors submitted specific comments about the State Office proposed process for these reviews. It did not appear the concerns had been resolved. Metric 2.i.2: The Facility had not conducted a full complement of 45 audits at least semi-annually, during the preceding 13 months. The State Office procedure was issued in March 2013, and the Facility procedure was dated April 10, 2013, so that, even though some audits were conducted prior to those dates, the process was not fully developed. The sample of four audits (Sample #D.6), provided during the onsite visit, had end-dates after the issuance of Facility policy. The Facility had conducted training, made assignments of staff to conduct the audits, and had a list of individuals to be audited with the dates of audit and an entry for completion of those already done. The lists showed six audits had been completed. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. In the four audits in Sample #D.6, all appeared to cover review of documentation for accuracy and consistency between	Noncompliance

#	Provision	Assessment of Status	Compliance
		documents in the individual's records. The audits included comments on findings, noting if injury reports had been filed and noting trends, such as the absence of documentation of peer-to-peer contact in observation notes. The audits indicated when an injury occurred, but the audit found that the nurse had not entered documentation of treatment (for example: Individual #27 on 4/16/13 of the audit). The audit process would benefit from the addition of a summary of each audit, highlighting any themes or trends discovered, the number of injuries noted, but not reported on a CIR, and any actions that were taken during the audit to remedy observed issues. The audit forms need to include the dates the audit was conducted and completed. Metric 2.i.4: The audits revealed a total of seven non-serious injuries had not been reported on Client Injury Report forms and those forms were initiated. No significant injuries were discovered. The audit forms need to contain the date of the audit and the date and time any discovered significant injuries are reported to the Director and/or DFPS. While the Facility Self-Assessment found substantial compliance, based on the establishment and implementation of an audit procedure, the Monitoring Team did not find substantial compliance. The audit process had been established in April 2013 and only six audits had been completed, which did not result in even one full semi-annual audit or to allow a track record long enough to determine compliance. Although significant progress had been made in the development and implementation of the process, the experience with the implementation was not sufficient to allow a determination of substantial compliance. As a result, the Facility remained in noncompliance with this provision.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified	DADS Policy Number 002.4: Incident Management, dated 11/20/12, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 021.2: Protection from Harm - Abuse, Neglect and Exploitation, dated 12/4/12,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	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 002.4 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. The training met the requirements of the Settlement Agreement. Seven DFPS investigators were trained in the requirements of the Settlement Agreement to enable them to conduct investigations at the Facility. The training records for these investigators were reviewed with the following results: ▪ Seven out of seven DFPS investigators (100%) had completed the requirements for investigations training. ▪ Seven out of seven DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The Incident Management Coordinator was a trained investigator, and had two investigators and six Campus Administrators who were trained as investigators on his staff. The training records for these investigators were reviewed with the following results: ▪ Nine out of nine Facility investigators and Campus Administrators (100%) had completed the requirements for investigations training.	

#	Provision	Assessment of Status	Compliance
		▪ Nine out of nine Facility investigators and Campus Administrators (100%) had completed the requirements for training regarding individuals with developmental disabilities. In March 2013, the Facility had started an on-the-job training program for all six Campus Administrators, by assigning them to work in the Incident Management Department once a month for direct training conducted by the investigators. This was done to enable the Campus Administrators to maintain their investigative skills, while not conducting investigations on a regular basis. The Incident Management Department produced cards with basic guidelines for the conduct of investigations that were distributed to Campus Administrators and Campus Coordinators. The Campus Coordinators did not conduct investigations, but were often present on site before investigators arrived and were able to secure evidence and take other early steps to facilitate the reporting and later investigation. The Facility remained in substantial compliance with this provision. The Facility Self-Assessment found the same.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Both State policy and LBSSLC policy required cooperation with outside entities conducting investigations of abuse and neglect. As described above in the Documents Reviewed section, Sample #D.1, which consisted of DFPS investigations, was reviewed. ▪ This review showed that in 15 out of 15 investigations (100%), Facility staff cooperated with DFPS investigators. In an effort to increase interagency collaboration, the Director of LBSSLC had continued to convene quarterly meetings with DFPS, DADS Regulatory, and the OIG to review issues related to investigations and the requirements of the Settlement Agreement. Minutes indicated no issues with cooperation. The Facility remained in substantial compliance with this provision. The Facility Self-Assessment found the same.	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	Substantial Compliance

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		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." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 15 investigation records from DFPS (Sample #D.1), 11 had been referred to law enforcement agencies. For 11 of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the nine investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies. The Facility remained in substantial compliance with this provision, since there was no evidence of lack of compliance with law enforcement agencies. The Facility Self-Assessment found the same.	
	(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 the Facility (Sample #D.2): ▪ Evidence that needed to be safeguarded was in 15 out of 15 (100%) DFPS investigations; and ▪ Evidence that needed to be safeguarded was in eight out of nine (89%) Facility investigations. In Sample #D.2.7, the UIR indicated there was blood on chairs and on the bed where an individual had sustained an injury. A nurse attempted to clean the area and resisted the instructions of the investigator to wait until photos had been taken. Upon interview with the Incident Management Coordinator, it appeared that this was a unique situation in which the nurse misunderstood the need for collection of evidence to take precedence over the important task of preventing any possible contamination from the blood. The nurse had been retrained on incident management procedures. 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	Substantial Compliance

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		cameras. Surveillance was provided 24 hours a day. The videotapes had been used successfully to identify and document abusive or neglectful practices. The tapes had provided important evidence that resulted in disciplinary action, including termination from employment. LBSSLC also used photographs to document injuries. These photographs were included in the investigation report files. The LBSSLC policy on "Incident Management: Managing Unusual Incidents" contained instructions on the use of photographs to document injuries. The Facility remained in substantial compliance with this provision. While the lack of cooperation in one investigation was serious, it did not appear to have compromised the investigation in the particular case in any substantial way and appeared to have resulted from a genuine misunderstanding of relative responsibilities. It also had been addressed properly to prevent recurrence. The Facility Self-Assessment found the same.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Both the DADS policy and the LBSSLC policies cited above required that investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. In order to determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ 14 out of 15 (93%) 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. The following was the investigation for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: o Sample #D.1.10 involved an allegation of physical abuse when a staff member forcefully pulled an individual by her jacket in an attempt to	Substantial Compliance

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		get her to enter a building. The allegation was called in within the first hour. While calls were made by DFPS to assure the immediate safety of the individual, staff was reassigned, and police were notified within the first 24 hours, the individual was not interviewed until three days later. In this case the individual communicated verbally, and might have had some recollection of the event, if she had been interviewed closer to the time of the alleged abuse. Interview of the individual should have been a priority investigation activity to preserve potential evidence. ▪ 14 out of 15 were completed within 10 calendar days of the incident, including sign-off by the supervisor. Sample #D.1.15 was not completed within 10 days: o For the one that was not completed within 10 days, one (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension; ▪ 15 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In none of the investigations reviewed, were recommendations for corrective action included. Three of 15 investigations resulted in Administrative Referrals, so no recommendation would have been expected from DFPS. In five of the fifteen, no recommendations were needed. In the remaining seven investigations, the companion UIR made the necessary recommendations. In all of the investigations (100%), where recommendations were needed, they were made by the Facility and were adequate to address the findings of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Nine out of nine (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. ▪ Six out of nine were completed within 10 calendar days of the incident, including sign-off by the supervisor: o For the three that were not completed within 10 days, none (0%) had documentation of a written extension request that had been approved by the Facility Director, and there was no documentation of the extraordinary circumstances that necessitated the extension. The three	

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		that were not completed within 10 days were Sample #D.2.1, #D.2.2, and #D.2.7. However, in each of the three cases preliminary versions of the UIR had been completed, signed and actions were being taken in response to recommendations before the final version of the report was signed. For example, in Sample #D.2.7, the serious injury occurred on 3/29/13 and the final URI was signed on 4/16/13. However, a level of support change was made and trained on 4/5/13, the IDT met on 4/10/13, a helmet was ordered on 4/12/13, and the nurse conducted neuro-checks, which were completed on 4/8/13. It appeared that action on recommendations did not await the final UIR. ▪ Nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In eight of the investigations reviewed, recommendations for corrective action were included. In one no recommendation was needed. Thus, in nine of the investigations (100%), the recommendations were adequate to address the findings of the investigation or no recommendations were needed. Two findings of the Settlement Agreement Team challenged the Facility's compliance with this provision. The first, the lack of recommendations in the DFPS reports was remedied by the inclusion of recommendations in the companion UIRs. While this practice was workable, it might not be sustainable in the event of a future change of practice by the Facility. The preferred practice would be for the DFPS reports to include recommendations or at least register concerns, particularly when an investigation finds failures to report as happened with Sample #D.1.13. The preferred practice would act as a check on the Facility to assure that all needed recommendations are made. The second finding that the Facility did not request extensions of time to complete three of its UIRs was partially remedied by the fact that the records contained multiple, signed versions of the UIRs one of which in each case was within the timeframe. In addition, action on recommendation proceeded based on earlier versions of the UIR. As a result, the Monitoring Team found this provision to be in substantial compliance with the caution that the Facility and DFPS need to reform their practices and the Facility needs to be certain to obtain extensions to complete UIRs in order or to identify which versions of a report are preliminary, final, and subsequent additions to remain in substantial compliance.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear	Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements.	Substantial Compliance

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	basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	Metric 3.f.2: The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations. The sample drawn was 15. However, three reports were administrative referrals and no investigation was made. The following metrics were based on the 12 investigations.
		▪ Metric 3.f.3: In 12 out of 12 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.4: In 12 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.5: In 12 (100%), the name(s) of all witnesses;
		o Metric 3.f.6: In 12 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.7: In 12 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.8: In 12 (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 Metric 3.f.9: In 12 (100%), all documents reviewed during the investigation;
		o Metric 3.f.10: In 12 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o Metric 3.f.11: In 12 (100%), the investigator's findings; and
		o Metric 3.f.12: In 12 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of Facility investigations:
		▪ Metric 3.f.13: In nine out of nine investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.14: In nine (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In nine (100%), the name(s) of all witnesses;
		o Metric 3.f.16: In nine (100%), the name(s) of all alleged victims and perpetrators;	

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		o Metric 3.f.17: In nine (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In nine (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 Metric 3.f.19: In nine (100%), all documents reviewed during the investigation; o Metric 3.f.20: In eight (89%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. The one that did not, was Sample #D.2.6, where the record indicated the individual had left the Facility without permission as a result of a dispute over tobacco. The issue of tobacco use had been raised in January 2013, and there was a request, dated 1/31/13, for restrictions to allow staff to provide the individual with tobacco on a planned schedule rather than on demand in order to prevent the recurrence of the issues related to tobacco use. When the issue was repeated in March, the team issued an ISPA indicating the program would be started, and there was evidence in the record of staff training on the plan. However, the UIR did not comment on the gap between the initial request for the restriction in January and the Unauthorized Departure in March that occasioned the investigation, so it was not clear if previous plans had been completely considered. o Metric 3.f.21: In nine (100%), the investigator's findings; and o Metric 3.f.22: In nine (100%), the investigator's reasons for his/her conclusions. It is important for investigators to reconcile the various pieces of evidence available and to note where not starting previous plans may have contributed to the more recent events. However, in spite of this one finding, the Facility was in substantial compliance with this provision. The Facility Self-Assessment found substantial compliance as well.	
	(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	Metric 3.g.1: The Facility policy and procedures did require that staff supervising the investigations review each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. Metric 3.g.2: The Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations:	Substantial Compliance

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	or areas of further inquiry in the investigation and/or report shall be addressed promptly.	▪ Metric 3.g.3: The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ Metric 3.g.4: 13 of 15 (87%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation as evidenced by the concluding date on the URI. The two that were not timely were: o Sample #D.1.4, where the UIR followed the DFPS report by 13 calendar days; and o Sample #D.1.10, where the UIR followed the DFPS report by 10 calendar days. ▪ Metric 3.g.5: The Facility Director/Incident Management Coordinator accepted at least ninety-four percent of the investigations over the six months prior to the onsite review. The three investigations that the Facility questioned were: o Facility Investigation #13-059 (DFPS # 42602396): Director upgraded from inconclusive to confirmed. This investigation was part of the D.1 sample for this review, designated as Sample #D.1.3. In that investigation, the Director requested a review of the DFPS finding of inconclusive with regard to physical abuse, indicating that some witnesses should be re-interviewed and video surveillance tapes should have been examined to determine how the injury to the individual occurred. Upon re-interviewing witnesses, DFPS changed their finding to confirmation of abuse. The Monitoring Team would not have had enough information to question the DFPS finding, had the Facility not taken the initiative to do so. o Facility Investigation #13-098 (DFPS #42678448): the Facility requested a methodological review, which resulted in a change from confirmed to unconfirmed; o Facility Investigation #13-128 (DFPS #42728587): a methodological review was requested, but the finding of confirmed was not changed. ▪ Metric 3.g.6: For none of the DFPS investigation files, the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. As a result, it would not have been expected that the Facility would have noted the problems with the investigations and/or reports, and returned the investigation to DFPS for reconsideration. ▪ Metric 3.g.7: In three investigation reports the Facility returned to DFPS for reconsideration, for three (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. <u>Facility Investigations</u>	

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		The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: nine of nine (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. This finding was based on the process used by the IMC for review, which involved multiple versions of the UIR prior to the final. For example: Sample #D.2.8 was started on 4/30/13; reviewed on 5/2/13 with mark-ups; reviewed again on 5/3/13, and finalized on 5/8/13. ▪ Metric 3.g.9: In nine out of nine investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ Metric 3.g.10: For five, the supervisor had identified concerns. For these investigations, for five (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ Metric 3.g.11: For the one investigation noted above in Metric D.3.f.20 where the Monitoring Team identified a deficiency, the supervisory review did not appear to address the deficiency. Two metrics did not meet the criteria for this provision (#D.3.g.4, which was at 87% and D.3.g.11 which did not have a positive response). Neither lapse appeared to substantially alter the investigations, the Facility was found to be in substantial compliance this provision. This was consistent with the Facility Self-Assessment. However, to remain in compliance the Facility should assure that DFPS investigations are reviewed within the five working days in the future and that supervisors review reports carefully for gaps in information that have not been reconciled.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Metric 3.h.1: The Facility-only investigations met the requirements outlined in Section D.3.f.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Metric D.3i.1: The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric D.3.i.2: In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. Metric D.3.i.3: For seven out of seven of the investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. Those included: Investigation Samples #D.1.3, #D.1.10, #D.1.12,	Substantial Compliance

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		#D.1.13, #D.1.15, #D.2.7, and #D.2.9. In these cases, which included employee termination, 10-day suspensions, letters of reprimand, and retraining, action was carried out promptly, often before the final date on the UIR. Based on a review of a subsample of investigations, Sample #D.5, for which recommendations for programmatic action were made, the following was found: ▪ Metric D.3.i.4: For seven out of seven of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. ▪ Metric D.3.i.5: For seven out of seven investigations (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The Facility was found to be in substantial compliance with this provision. The Facility Self-Assessment found the same.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Based on review of Facility policy, records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. Earlier reports 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 had remained secure and accessible to the investigators as needed. 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.	Metric D.4.1: For all categories of unusual incident categories and investigations, the Facility did have a system that allowed tracking and trending by: ▪ 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. Over the past two quarters, the Facility's trend analyses: ▪ Metric D.4.2: were conducted at least quarterly; ▪ Metric D.4.3: addressed the minimum data elements; ▪ Metric D.4.4: used appropriate trend analysis procedures; ▪ Metric D.4.5: provided a narrative description/explanation of the results and	Noncompliance

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		conclusions; and ▪ Metric D.4.6: Did not**,** as appropriate, contain recommendations for corrective actions. QAQI Council minutes did not reflect discussion of the trends and what actions might be needed to address them. For example: o In the 4/25/13 Executive Safety Committee presentation of trend data, individuals with high frequency of involvement in reports of allegations, injuries, restraints, peer-to-peer aggression and staff injuries were ranked ordered to show which individuals were most at risk of continued involvement. This was an excellent presentation, making it possible to identify who needed additional intervention to reduce the frequencies. The report noted that one individual had dropped from appearing across five categories to three and credited the IDT's efforts as helping to achieve that reduction. However, there were no notes indicating whether similar efforts were underway with others on the list, and no record of the Council inquiring about them. o The 4/25/13 trend reports were presented to the QAQI Council on 5/14/13. The notation in the minutes of that meeting indicated that there was discussion about the reliability of the data, with no indications of actions to be taken. Much of the data reviewed showed positive trends. There was a marked downward trend in injury reports over six months, and in DFPS confirmations and in DFPS inconclusive findings over the three years. The latter was important to monitor, since investigations that do not conclusively determine whether or not there was abuse leave open the possibility that abuse did occur, the possibility that the investigation was not thorough enough, or might show a trend that requires further review (e.g. a staff member that is repeatedly involved in allegations that are found to be inconclusive). However, the data describing DFPS dispositions by home that suggested home #516 was experiencing a high number of dispositions, both confirmed and unfounded, suggested further investigation and possibly action. It appeared that trending and analysis of data was progressing, but that the connection to action plans/corrective action plans was not yet complete. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed, at least not regularly as described above. Metric D.4.8: As appropriate, corrective action plans were not developed both for specific	

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		individuals and at a systemic level. Metric D.4.9: The trend reports and/or minutes did not show that corrective action plans were implemented and tracked to completion. Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective actions, except that the Executive Safety Committee did comment on the reduction in issues across categories for one individual was likely the result of the IDT's efforts. Since no action plans/corrective action plans directly related to data trends/analysis were available for this review, the following metrics could not be completed. As action plans/corrective action plans become available, future reports will assess them, based on the following metrics: ▪ Metric D.4.11: ___ out of ___ action plans (__%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ Metric D.4.12: For ___ out of ___ of the action plans reviewed (___%), the plan had been timely and thoroughly implemented. ▪ Metric D.4.13: For ___ out of ___ action plans (___%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. The Facility was not in substantial compliance with this provision. However, progress in producing, analyzing and presentation of trend data was substantial. The final step of adopting action/corrective action plans to address the data remained to be accomplished. The Facility's Self-Assessment had found this provision to be in substantial compliance based on the improvements in trending data and on the reviews by the Executive Safety Committee, the QAQI Council and other groups, such as the Peer-to-Peer Review Committee. The Facility cited directions for corrections, which were made by the various groups to the IDTs and review of IDT responses. However, the instructions to act based on data trends were only minimally evident in plans or minutes, and more systemic action plans were not in place to address identified trends.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more	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	Substantial Compliance

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	than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of September 2012. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that one employee had been terminated based upon a background check. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility. The Facility remained in substantial compliance with this provision. The Facility Self-Assessment found the same.	

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 DADS Policy #003.1: Quality Assurance (QA), dated 1/26/12; o LBSSLC Policy "Review Processes: Quality Assurance Process/Plan," dated 8/30/12; o Presentation Book for Section E; o LBSSLC Self-Assessment, dated 6/20/13; o Quality Assurance/Quality Improvement (QAQI) Council Meeting: Addressing April 2012 through September 2012 (trend analysis report), dated 11/7/12; o LBSSLC Executive Safety Committee – Addressing May 2012 through October 2012, presented 11/29/12; o December 2012 QAQI Meeting – Addressing May 2012 through October 2012, presented 12/5/12; o LBSSLC Executive Safety Committee Meeting, dated 1/31/13; o LBSSLC Executive Safety Committee – Addressing June through December 2012 (trend analyses), presented 1/31/13, revised 2/5/13; o QAQI Council Meeting – Addressing June 2012 through December 2012 (trend analyses), presented 2/14/13; o LBSSLC Executive Safety Committee – Addressing August 2012 through January 2013, presented 2/27/13; o QAQI Council Meeting – Addressing August 2012 through January 2013, presented 2/28/13; o LBSSLC Executive Safety Committee – Addressing September 2012 through February 2013, presented 3/27/13; o LBSSLC Executive Safety Committee – Addressing October 2012 through March 2013, 4/25/13, revised 5/7/13; o QAQI Council Meeting – Addressing October 2012 through March 2013, revised 5/6/13; o QAQI Council Meeting – Addressing November 2012 through April 2013, created 5/14/13 o LBSSLC Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 7/9/13; o Injury Trend Report – 2/27/13, for March (undated), for April (undated), o Quality Assurance/Quality Improvement Council meeting notes, dated 11/7/12 through 5/14/13; o Monitoring tools associated with the Quality Enhancement Plan; o LBSSLC Performance Indicators (part of the Presentation Book), undated; o Basic Data Analysis, undated; o QAQI Council Schedule, updated 2/1/13; o QAQI Quarterly Section Review of Settlement Agreement Progress, revised 1/15/13; and o Sample #E.1: the minutes of meetings between the QA Department and the Discipline Department, held to review and analyze QA data and to consider corrective action plans for the following sections, selected at random: Sections D, I, M, Q, and U.

	▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs; o Dawn Ripley, Quality Assurance Director (QAD); o Rodney McWilliams, Incident Management Coordinator; and o Program Compliance Monitors. ▪ **Observations of**: o Site visits to nine residences (i.e., 513, 514, 515, 516, 517, 518, 523, 525, and 526), and the workshop. o Incident Management Review Team Meeting, on 7/10/13; o Executive Safety Committee meeting, on 7/11/13; o Quality Assurance/Quality Improvement Committee meeting, on 10/3/12; o Self-Advocacy meeting, on 7/9/13; and o Unit I and II morning meeting, on 7/10/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 6/20/13. 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. The Facility rated one of the five provisions in Section E as being in substantial compliance. The Monitoring Team found the same. For Section E, in conducting its self-assessment: ▪ The Facility did not use the results of applying the QA monitoring/auditing tools for the Self-Assessment, though there was evidence in the files that the QA tool was in use. ▪ The Facility used other relevant data sources, such as reviewing procedures, meeting minutes, and corrective action plan logs. The Facility did not use probes or other devices to audit for outcomes of Corrective Action Plans (CAPs) or to test performance of steps within CAPs. ▪ The Facility did not consistently present data employing charts or graphs. However, much of the data provided were dates of meetings and narrative descriptions of information provided in those meetings. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators. For example, in Section E.2.1, the activity engaged in to conduct the self-assessment was "Review QAQI Council minutes to determine regular review of data/analysis with recommendations for corrective action made, as needed." To do this, the QAD reviewed six months of meeting minutes, but made no mention of how many corrective action plans resulted in comparison with the number of corrective action plans that should have been developed based on the content of the minutes. o Did not consistently measure the quality as well as presence of items. For example, E.2.3 indicated that two CAPS had been completed and the outcomes had been met. However there was no indication of whether there had been any measurement of the outcome to verify that it had been met. ▪ The Facility data did identify some areas in need of improvement. For example, it was noted in E.2.4 that QAQI Council minutes needed to be expanded to include the discussion of barriers to

	implementation of CAPs, and in E.2.3, that completion and presentation of evidence was not always timely. The need for CAPs to include measureable outcomes was identified, as was the need for the minutes of QAQI Council meetings to include discussion of the timely implementation of CAPs. The Facility noted that there was discussion at Council meetings about needs for expansions of time for CAPs, but not for modifications or improvements to CAPs.
	Summary of Monitor's Assessment: The Monitoring Team found the Facility to be in substantial compliance with one of the five provisions of Section E. Although it is not reflected in an increase in substantial compliance scores, since the Monitoring Team's last visit, the Facility had made progress with regard to Section E, including: ▪ The Executive Safety Committee was producing and reviewing data on incidents, injuries, and restraints, and trending and analyzing the data over time. The committee employed a variety of trending techniques, including graphing incidents, injuries, and restraints together to examine any correlations. Examinations of data by the Committee were thorough and productive, netting ideas on both changes to data displays, and on what data was most important to determining actions and setting priorities. This kind of attention to data analysis was a significant and positive step forward. ▪ Considerable work had been done to develop key indicators of performance (labeled "Performance Indicators"). A list had been produced, grouped by Settlement Agreement Section, with input from section leaders that included the definition of the indicator, the responsible staff, the database for data entry, the target, the baseline, the current status, and the measurable outcome. In June 2013, the use of the Performance Indicators began with Section D. Although as discussed in further detail below, more work was needed with regard to the key indicator system, this work represented a giant step forward. ▪ A PowerPoint presentation, Basic Data Analysis, had been developed by the Incident Management Coordinator, approved by the QAQI Council, and distributed to Department Heads. The presentation, based on work by an external consultant group's Protection from Harm Regional Training, was designed to highlight some key elements of data analysis in a manner that should prove useful to managers of services. ▪ Department heads had been provided with a revised quarterly review format for use in developing presentations to QAQI. The format included the status of CAPs and information on barriers, need for modifications, and other information to assure accurate tracking. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ Key indicators: to review and refine the performance measures to reflect the priorities of the Facility, to increase the indicators that describe outcomes for the population served (how their lives will be improved), not just the output of various management activities (how well staff are performing their duties). ▪ CAPs development: to encourage the development of CAPs that result from data reviews and trend analyses. This necessary step toward compliance will demonstrate that the Facility can use data to inform plans for improvements in peoples' lives. ▪ Data Inventory: complete a data inventory that pulls together in one place information on the

	databases that are used to produce reports, making sure that all data collected in the QA monitoring process as documented in the QA matrix, appears in the data inventory. ▪ Data analysis: Work on providing data summaries and analyses in presentations of QA data to departments to help them in formulating responses and improvements, and document discussions of those summaries and analyses in the meeting minutes. ▪ Compliance scores: avoid relying on or referencing single overall compliance scores and instead, draw attention to the specific data that indicate a need for action or CAPs.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	**State QA policy** There was a State policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the State policy, entitled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: ▪ It seemed to have reserved policies for statewide development, and procedures for Facility development. This will keep the terminology consistent and the Facility should not have to re-label the State policy to adopt it. ▪ It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. ▪ The policy language was simple and straightforward and the bullet style will make it easy for staff to read. ▪ It required disciplines to keep account of their databases and the QA Department to keep track of all databases. Other comments: ▪ The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the Facilities to have procedures to deal with both. ▪ There did not appear to be a list of key indicators or a directive to develop a list. ▪ The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State Office should consider this. **Facility QA policies** Facility policies and procedures related to quality assurance (as listed in Documents Reviewed) were examined and found to support/implement the State QA Policies.	Noncompliance

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		QA data list/inventory of data The Facility did not maintain a data list/inventory that identified data for all sections of the Settlement Agreement that could be used to identify trends related to the requirements of those provisions of the Settlement Agreement sections. However, a partial list of databases was available as well as a list of reports that were run from those databases, although there was not a clear description of which databases were the source for the various reports. A list of all databases containing data relevant to the Settlement Agreement should be compiled so that it is clear where the data resides that is pulled into reports. The data list/inventory did not include data on key indicators (i.e., outcome and process) of performance, selected by the QAQI Council to track priorities. While a list of performance indicators had been compiled, some of the data needed for measuring those indicators might have been included in the various databases on the data list, but it was not clear where all of this data was maintained or if it needed to be added, or that there was a report that would pull together the data needed to measure the performance indicators. The partial data list/inventory appeared to include data from: ▪ Settlement Agreement self-monitoring tools: ▪ Disciplines/departments; ▪ Areas of Care; ▪ Protections; ▪ Supports; and ▪ Services. However, the Monitoring Team could not conclude this from the presented data list, but only from the experience of reading the various trend reports provided for other purposes. It was not clear that data list/inventory included data recorded/broken down by: • Program areas; • Living units; • Work shifts; and • Individuals. But, in fact, such data was in use in reports for restraints, injuries, and incidents. The list/inventory did not include a description of the data such as its source, how often the data was updated, how it was accessed, and who were the primary users of the data.	

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		The data list/inventory was not current according to Facility policy in that it did not have the date it was produced on the list. It was not clear that Facility policy required updating of the data list/inventory at least every six months. **QA Plan Narrative** The QA plan narrative at the Facility was determined to be the document entitled, LBSSLC – Review Processes: Quality Assurance Process/Plan. This document was dated 8/30/12, and was current and had been revised within the last year. The QA plan narrative did not completely describe the QA program, including at a minimum: ▪ A description of the purpose of the QA program was found on page nine of the narrative. ▪ The organizational structure of the QA process was described in the section of the narrative, called STEPS. It included the functions of the State QAQI Council, the Facility QAQI Council, the membership, the role of the Director, the functions of the QA Department, and the functions of the Discipline Departments. ▪ The data list/inventory: as indicated under QA Data List/Inventory, above, while there was the beginning of a list, it was incomplete in that it did not include all necessary data such as performance indicators, and did not have complete descriptions of the databases or descriptions of the connections between the databases and each report. The data list also needed a date to establish when it was last updated. ▪ QA matrix: The QA plan did include a matrix; ▪ There was a list of performance indicators, but it was not complete. It included data points that might be useful to track, such as the number of volunteers or the fill rate for positions, but did not provide a measure of the desired outcome for individuals. Such indicators measure the inputs into the system not the outputs that are the resulting improvements in the lives of individuals. ▪ A partial description of how data are summarized and analyzed was included in the functions of the QA Department, indicating that the department "conducts statistical analysis of data and database design." This statement lacked details about the various sorts of data tracking and analysis that would be done and the roles of the State and local data tracking for quality assurance. ▪ The role of other departments in QA was included, but it was not clear that there was an expectation that department heads and QA staff would meet regularly to review and analyze data, and determine if corrective action plans might be needed. ▪ It was not clear how workgroups were to be formed and what their reporting responsibilities would be. ▪ The plan did describe how the QA Department would formulate reports and how often and how they would be disseminated.	

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		▪ The plan did describe the QAQI Council and its role in reviewing data and guiding the entire QA process. However, while there was reference to the QAQI Council's responsibility for tracking corrective action plans, there was little description of how that was expected to happen. **QA Plan Matrix**: Key Indicators: 1. For the 20 sections of the Settlement Agreement, the matrix referenced a set of key indicators, labeled as performance indicators, for 18 of the 20 sections (90%). The individual performance indicators were listed separately from the matrix in groups, which appeared to be by Settlement Agreement section, but the groups were not labeled by section. Because the groups of performance indicators were not labeled by section it was not possible to determine with certainty whether there were indicators for all 18 sections as listed in the matrix. However, there were 17 groups of indicators. One group appeared to be indicators for activities unrelated to a specific section. 2. Thus, of the 18 sections indicated in the matrix as having performance indicators, both process and outcome indicators were identified for 16 (89%) of the sections. 3. Of these 17, in 0 (0%) the indicators provided data that could be used to identify the information specified in E1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. As noted above, these key indicators were a good first step, but for none of the sections of the Settlement Agreement were they sufficient in scope to allow for the level of oversight described in this subsection of the Settlement Agreement. In addition, as an example: on page 3 of the performance indicators one outcome indicator was listed as "# of ANE allegations will reduce by 20% by the end of FY." While data existed that would allow data to be trended as required (e.g., across program areas, work shifts, etc.), and in fact, there were already reports that did so, nothing in the performance indicator lists specified that the trending would happen or how it would happen. Self-monitoring tools for Settlement Agreement provisions: The QA plan matrix did include self-monitoring tools/self-monitoring procedures for the 20 sections of the Settlement Agreement. Although Section I monitoring had been suspended, pending development of a new tool. Copies of tools were provided for all sections. Data Collected by QA Department All data that QA staff members collected were listed on the matrix.	

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		Items in QA Plan Matrix Also Appear in the QA Data List/Inventory The Facility appeared to have grouped the QA monitoring data under the heading POI Data, but did not list the sections separately, so it was not possible to determine if all the items in the QA Matrix were in the data inventory. Data in QA plan matrix were submitted and reviewed ▪ Submitted/received: From review of documentation, it was not clear how the Facility was tracking whether data required by the matrix was being submitted and reviewed. The QAQI minutes included information each month on reports presented, and meeting minutes of QA staff's meetings with discipline heads were available. However, it will be important going forward to track that information in a summary form to stay informed about where any gaps in performance might be developing. From another perspective, it was possible to see from the matrix what was expected to be done. It was not possible to determine with certainty, whether each section had performed as expected. However, based on a review of the evidence of monitoring submitted in response to IV.4 of the document request, it was determined that: o Of the 20 items in the QA plan matrix, 14 (70%) were submitted/collected/received by the QA Department for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were not were Sections I (suspended), K (only three months), F (January missing), and G, H, L (sections on constipation, diabetes, osteoporosis, seizures, and emergency room visits). • Reviewed/analyzed: o Of the items in the QA plan matrix, 15 (75%) were documented to show some review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item. This was determined based on whether at least two Quality Assurance Quarterly Summary forms were found in the files submitted in response to IV.4. Those without two forms included Sections F, I, M, S, and U. o For the 19 sections of the Settlement Agreement (Section E excluded), for 16 (84%) there was some, often minimal, documentation, usually in the monthly meeting notes, indicating that QA staff had assisted the section leads with analysis. For those sections without documentation of assistance, there was no explanation of the reasons that assistance was not needed. The sections where there was no documentation of assistance were: • Section I, which had been suspended pending development of a new form; • Section J, where no indication of analysis by QA staff was	

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		available; and • Sections G, H and L where there was no analysis by QA staff. As the QA Director and the Department section leaders work towards improving the self-monitoring tools, the Facility should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: 1. Content/validity: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and evidence that each tool received a review by QA/QI Council at least twice within the past six months. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, (a) the content of ___ (%) appeared to be appropriate and (b) __ (%) were reviewed within the past six months, and revised as appropriate.) 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, ___ (%) had adequate instructions for the user.) 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. [Metric to be measured: Since the last onsite review, of the self-monitoring tools for the 20 sections of the Settlement Agreement, ___ (%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement).] 4. QA review: A report or summary showing that there was documentation of QA Department review of the results of the monitoring, at least once each quarter, for each of the 20 sections of the Settlement Agreement. (Metric to be measured: Since the last onsite review, of the 20 sections of the Settlement Agreement, there was documentation that the implementation (including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for ___ (%) of the 20 sections.) While there was definite progress in revision of monitoring tools, development of performance indicators, and beginnings of a data inventory, there remained much work to be done to assure the usefulness of these processes. The Facility was not in compliance with this provision. The Facility Self-Assessment found the same.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address	**Data and QA Reports:** Data from the QA plan matrix for none of the 19 (0%) sections of the Settlement Agreement (not section E) were appropriately: ▪ Summarized;	Noncompliance

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	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.	▪ Graphed showing trends over time; and ▪ Analyzed across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals. Data must be presented over time for a long enough period to permit assessment of trends; graphs need to present data in ways that facilitate analysis; and the analysis needs to result in the identification of common issues and/or underlying causes of those trends or issues. **Regular Meetings Between Discipline Department and QA Staff** <u>Reviewed QA-related Actions</u> Based on a review of a sample of five of the 19 (i.e., 26%) sections of the Settlement Agreement, (i.e., Sections D, I, M, Q, and U), the minutes of meetings between QA staff and discipline heads for the last two quarters: ▪ A meeting occurred at least twice for four (80%) of the sampled sections of the Settlement Agreement. The one that did not was Section I, which had been suspended pending development of a new tool. ▪ The minutes of the four meetings that occurred documented that the reviews that occurred in each meeting included the following: o In 0%, review of the data listing/inventory and matrix, since a complete data listing/inventory was not available; o In 100%, discussion of the data and outcomes, o In 100%, review of the conduct of the self-monitoring tools, o In 75%, creation/proposal of corrective action plans. Section M had considerable data, which had been summarized to reveal areas in need of attention, yet did not pursue the development of corrective action plans. Section I had been suspended. o In 0%, review of previous corrective action plans. However, none of these sections had corrective action plans in process. <u>Data Available</u> ▪ Since the last onsite review, during four of the four (100%) sampled meetings, data were available to facilitate department/discipline analysis of data. Only Section I had no data available. <u>Data Reviewed/Analyzed</u> ▪ Since the last onsite review, during four of the four (100%) sampled meetings, data were reviewed and analyzed. Some, such as section M, had detailed analysis of some of the data and had summarized some data to make it easier to select areas to concentrate attention via corrective action plans or other activities.	

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		▪ Since the last onsite review, during none of the four (0%) sampled meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. **QA Reports** According to the Director of Quality Assurance, QA did not prepare a single quality assurance report for discussion and distribution. Instead, QA prepared a report on each section of the Settlement Agreement once per quarter and made it available to the Section Leaders for incorporation into their quarterly reports to the QA/QI Council. The minutes and attachments of QAQI Council meetings affirmed this. Since the last onsite review, Facility QA reports were created for all of the six (100%) months (November 2012 through May 2013). Of the 20 sections of the Settlement Agreement, 13 (65%) appeared in a QA report at least once in each quarter since the last onsite review. Those that appeared once in six months were: Section F (suspended monitoring March to May to convert to a new form), and Sections N and O, which underwent some form conversion. Those that did not appear in the last six months included: Section G-H-L where the monitoring was not done by the QA Department, and Section I, which had been suspended Of the sections of the Settlement Agreement that were presented, none of 20 (0%) contained all of the following components: a. Self-monitoring data i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate. b. Key indicators i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate. However, most included self-monitoring data with some analysis. <u>Facility QAQI Council</u> Design: There was an adequate description of the QAQI Council in the QA plan/policy narrative. The QA plan/policy narrative listed the Facility Director as chairing the QAQI Council and listed the discipline heads and other key members such as the Settlement Agreement Coordinator, as members. The narrative provided for additional department staff as necessary to attend or facilitate a discussion. Schedule, agenda, and attendance: Since the last onsite review, the QAQI Council met at least once each month. Minutes from 10 of the 10 (100%) QAQI Council meetings since	

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		the last review indicated that: ▪ Meetings occurred according to schedule or reasons for changes were documented; ▪ Agendas included topics/presentations related to QA; and ▪ There was attendance/representation as per policy. Data and Analysis Presented: Minutes from none of the 10 (0%) QAQI Council meetings since the last review documented that: ▪ Data from QA plan matrix (key indicators, self-monitoring) were presented, chiefly because the key indicators were under development and data had not been established for many of the sections; ▪ The data presented were trended over time. While there were trend reports on injuries, incidents, and restraints that trended data over time, most data resulting from monitoring had not been trended over months or years, and as indicated above, key indicator data was just beginning to be collected/used. ▪ Comments/interpretation/analysis of current data were presented. Significant comments, interpretation and analysis of data accompanied the trend reports as presented by the Executive Safety Committee to the QAQI Council. Examples include: explanations of discrepancies in injury data as reported by Risk Management and Incident Management; reasons for the rise in restraints in a particular month; lists of individuals with a high frequency of allegations, injuries, restraints, peer-to-peer aggression, and staff injuries for the period of a month. In addition, some of the Section reports presented to QAQI Council included some comments and interpretations, but this was an area that required further expansion. It was noted that the Council had a presentation/training on January 31, 2013 called "Basic Data Analysis" taken from the contractor's Protection from Harm Regional Training. The brief, but useful presentation, included the basic concepts of data analysis and helpful hints about how to approach analysis. The Facility deserves recognition for making this information available to the Council. Recommendations and Corrective Action Plans: ▪ Of the three corrective action plans presented during the months from November 2012 through May 2013, none (0%) were based on the data presented. They resulted from the regulatory survey and the need to comply with the findings of the survey rather than from the Facility's own monitoring data, and ▪ None of the three corrective action plans presented addressed both high-risk individuals and systemic issues.	

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		On 7/9/13, members of the Monitoring Team attended the meeting of the QAQI Council. Presentations for sections followed a pre-established format, referenced the QA monitoring results, noted overall compliance rates but qualified them by noting where issues were identified, and provided information about meetings between the discipline and the Program Compliance Monitors. Each report noted whether or not a corrective action plan was being proposed or explained why one was not needed. The council members posed some questions, but the reports did not lend themselves to much discussion. **Corrective Actions and CAPS** System for generating CAPs: A written description existed in the "LBSSLC-Review Processes: Quality Assurance Plan/Process" that indicated how CAPs were generated, but it did not meet the standards for describing CAP development. The description included: ▪ Criteria for a CAP as being identified through the QA process, but did not provide guidance as to what factors might require or at least suggest the need for the development of a CAP; and ▪ No description of how to evaluate indicators for criteria, or cautions that evaluation should not be by percentages alone. CAP development: When considering the full set of three CAPs developed in the previous six months, none (0%) appeared to have been chosen following the written description, policy, or procedure. They were not based on data analysis and the quality assurance process as described in the QA Plan. Instead, the CAPs were based on a survey and certification report that identified gaps in compliance with the certification rules. There was nothing wrong with using the CAP protocol to address the certification issues, and the use of the CAP protocol appeared to have addressed the identified issues (given that during the Monitoring Team's onsite visit, the Facility was deemed to have come into compliance with the certification concerns identified). However, there was no demonstration that the QA system was using the Facility-generated data to identify and address issues via corrective action plans. Content of each CAP: Of the three CAPs developed in the six months prior to this monitoring visit and reviewed by the Monitoring Team, all (100%) appeared to address the specific problem for which they were created, since all were directly based on the finding in the regulatory reports. CAPs contain all necessary components: Based on a sample of three CAPs, which represented 100% of the total of three CAPs: ▪ All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence.	

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		▪ All (100%) included the anticipated outcome of each action step. ▪ All (100%) included the person(s) responsible. ▪ All (100%) included the time frame in which each action step must occur. The Facility remained out of compliance with this provision based on the findings described above. The findings of the Facility were the same.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of 11 CAPs, which represented 100% of the total of 11 CAPs that had been completed as of 6/6/13, there was documentation that indicated: ▪ How each CAP was disseminated (100%); ▪ When each CAP was disseminated (100%); and ▪ The specific person(s) responsible to whom the CAP was disseminated (100%). 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. The Facility Self-Assessment made a similar finding.	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.	As was noted in previous reports 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 of 1/15/13, the Facility had adopted a QAQI Quarterly Section Review of Settlement Agreement Progress form to be completed by each Department Head on a quarterly basis. The form included a place to enter the status of CAPs (i.e., date approved by council, success or lack of success based on data, barriers to success, and need for modifications). These forms appeared to be in use as of the 2/14/13 QAQI Council meeting. A random review of the forms submitted for the 2/14/13 meeting indicated few CAPs. The form for Section E summarized the status of incomplete CAPs indicating extensions of time with reasons, but did not provide additional information on whether CAPS were meeting the desired outcomes.	Noncompliance

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		Implementation of CAPs: Based on a sample of 10 completed CAPs and five in process CAPs, nine of the 15 (60%) were implemented fully and two (13%) were implemented in a timely manner. This was determined by reviewing the Corrective Action Plan Tracking to see if the status of on-going CAPs was updated, or whether there was an indication of completion. The CAP tracking sheet did not provide status updates other than to indicate whether there had been a change in due date or whether the CAP had been discontinued or merged with another action plan or CAP. Tracking CAP status: There was a partial system for tracking the status of CAPs, but it did not provide status updates, such as whether the CAP had progressed from one step to another. Of the 15 CAPs being tracked by the Facility, for 15 (100%), the tracking sheet indicated the status of the CAP as to whether it was still open or had been closed or discontinued, but it was not clear at what stage of implementation an open CAP might be. When a CAP had been discontinued, it was not clear whether it had ever been even partially implemented. Management of CAPs: The Facility QA Director: ▪ Did maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review in the sample of CAPs; and ▪ Did present this information to QAQI Council at least quarterly. While the Facility was logging CAPs on its tracking sheet and indicating whether their completion dates had been extended, when CAPs were discontinued, combined with another plan or were incomplete, the CAPs tracking sheet lacked intermediate status information, which is key to monitoring whether a plan is being fully implemented. The Facility remained out of compliance with this provision.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Evaluate effectiveness of CAPs: LBSSLC was not in substantial compliance with this provision. The QA Director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. Once a system is developed, based on a review of a sample of CAPs, the following metrics will be used to assess the Facility's compliance: ▪ For ___out of ___CAPs (%), documentation showed review of their effectiveness (i.e., outcomes), and for ___out of ___CAPs (%), documentation showed review of their timely completion. ▪ Of the ___ CAPs that appeared to need modification, ___ (%) were modified.	Noncompliance

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		▪ Based on a sample of ___ completed CAPs and ___ in process CAPs, ___ (%) were discussed at QAQI Council. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show timely implementation. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show full implementation. In order to track CAPs for needed modifications and effectiveness, each CAP should be assigned a tracking number that could be used to label evidence of completion or on-going evidence of the status of activities. Where Council meeting minutes contained the evidence of completion or effectiveness, those meeting dates should be referenced on the tracking sheet. The Facility remained in noncompliance with this provision.	

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 004.1: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, 11/20/12; o DADS Policy #006.3: At Risk Individuals, dated 12/7/12; o Instructions for ISP Meeting Guide, revised 11/20/12; o Presentation Book for Section F; o Timeline for Section F, September 2012 through August 2013; o Most Recent ISP Dates, Dates ISPs were Filed and Previous ISP, for 5/15/12 through 5/15/13; o Data on ISP timeliness, for 4/15/12 through 4/15/13; o Assessment data report, for June 2012 through June 2013; o Assessment data report for June 2013; o Data report on team member participation in annual ISP meetings, for 4/1/12 through 4/31/13; o Quality Assurance/Quality Improvement Council minutes, for 12/5/12; o ISP Committee Report for QA/QI Council, dated 12/5/12; o Key Performance Indicator Worksheet related to ensuring individuals live in their most integrated setting with needed supports, dated 6/7/12; o SSLC Action Plans to: 1) Improve Personal Functional Assessments; and 2) Improve Community Living Options Plans; o Completed CAP Tracking Log, dated 6/6/13; o List of individuals admitted over last six months, including date of admission and date of initial ISP meeting, for 11/15/12 to 5/15/13; o Individual Support Plan Annual Assessments Spreadsheet for ISPs Facility provided in response to pre-review document request; o Individual Support Plans, sign-in sheets, Annual Integrated Risk Rating Forms, Annual Integrated Health Care Plan, Skill Acquisition Program, ISP Preparation Meeting documentation, assessments completed for the ISP meeting, for the following individuals: Individual #30, Individual #242, Individual #290, and Individual #276; o Sample Annual ISP meeting data regarding incidents and allegations; o Monthly Review Tracking data, from October 2012 through May 2013; o Individual Support Plan Meeting/Documentation Monitoring Checklist, undated; o ISP Quality Check, undated; o Draft ISP Monitoring Checklist – Instructions, revised March 2013; o Annual ISP Meeting Preparation Checklist, revised 3/7/13; o Last 10 monitoring tools the QDDP Department completed, various dates; o Last 10 monitoring tools the QA Department completed for Section F, various dates; o Qualified Developmental Disabilities Professional (QDDP) Training Curriculum, example

	for month of January 2013; o QDDP Department Meeting minutes, dated 11/19/12, and 2/21/13; o Data for March 7, 2013 Provider Fair; o Supporting Visions: Personal Support Planning Training, dated 9/12; o Q Construction: Facilitating for Success competency tools, undated; o Settlement Agreement Cross Referenced with ICF-MR Standards: Section F: Integrated Protections, Services, Treatments, and Supports, revised August 2010; o QDDP Facilitation Skills Performance Tracking, dated 5/24/11 (appears to be incorrect date); o QDDP Current Assignments and Number of Individuals on Their Caseload, undated; and o ISP Workgroup Presentation Book. ▪ **Interviews with**: o Sandra Kennedy, QDDP Coordinator; Christina De Los Santos, QDDP Educator; Jessica Smith, QDDP Educator; Marc Lopez, ISP Technician; and Ric Savage, State Office Consultant; o Libby Allen, Facility Director; Tammy Marshall, Settlement Agreement Coordinator; Robin Seale, Assistant Director of Programs; and Ric Savage, State Consultant. ▪ **Observations of**: o ISP meetings for the following: Individual #290, and Individual #276; o ISP Preparation Meeting for Individual #3.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 6/20/13. 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. The Facility's progress with this process is discussed in further detail with regard to Section F.2.g. However, based on a review of the Facility's Self-Assessment: o The Facility was in the process of starting to use a new audit tool entitled: Annual ISP Meeting Preparation Checklist, dated 3/7/13. However, this was in the beginning stages of implementation. Documentation submitted also included the tool entitled: Settlement Agreement Cross Referenced with ICF-MR Standards – Section F: Integrated Protections, Services, Treatments and Supports. In response to a request for the last 10 monitoring tools from the QDDP Department and the last 10 from the QA Department, the completed tools the Facility submitted were on this form. Two other tools also were provided in other documentation including: 1) LBSSLC Individuals Support Plan Meeting/Documentation Monitoring Checklist; and 2) ISP Quality Check. It was unclear which audit tool(s) were used to complete the indicators in the Self-Assessment. More specifically, it appeared that some indicators from the various tools were included in the Self-Assessment, but when asked for recent raw data, examples of only one tool were submitted.

	o Although these various auditing tools included some valuable indicators to assist the Facility in determining its compliance with the requirements of the Settlement Agreement, some significant concerns remained with regard to the indicators. Some of them could be answered in the affirmative without the auditor assessing the quality as opposed to just the mere presence of an item. This, amongst other factors, likely contributed to the much higher ratings the Facility calculated for specific sections of the Settlement Agreement in contrast with the Monitoring Team. The following are just a couple of examples from the Annual ISP Meeting Preparation Checklist, which was identified as the tool that would be used moving forward: 1) Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate; or 2) Was the ISP meeting Guide completed, including the personal preferences and strengths? Either of these could be rated as compliant without the quality being assessed. o Draft instructions were submitted, but these were extremely general and did not identify standards for assessing compliance. o Clearly efforts had been made to expand the scope of the indicators included in the Self-Assessment, and this resulted in some improvements. However, the indicators included in the Self-Assessment did not represent the full set of indicators necessary to assess compliance. Again, at times, quality as well as the presence of items seemed to be overlooked. For example, although the Facility recognized the need for quality assessments, the Self-Assessment measured limited quality indicators for assessments (i.e., inclusion of preferences, strengths, and needs; and "current and reflect the necessary changes," which was not defined. As the Facility revises its monitoring tools, the Facility continues to be encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o Based on review of the audit tool, it generally included adequate methodologies, such as observations, and record reviews. However, these methodologies were not sufficiently detailed 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. It 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). By providing this percent sample size, the relevance to the overall population could be quickly identified. o The following staff/positions were responsible for completing the audit tools: the Program Compliance Monitor and the QDDP Coordinator. o Although the staff responsible for auditing had some level of relevant programmatic experience, it was not 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 area(s). o Based on data submitted with regard to auditing that occurred in May 2013, inter-rater reliability was estimated to be between 90 and 95%. However, based on the Facility's findings that month that showed 100% compliance with all but a few indicators in

	comparison with the Monitoring Team's findings related to some of the most recent plans, it appeared that the Facility's monitoring might be reliable, but it was not valid. This is particularly problematic, because the Facility's Self-Assessment will not be accurate, and, as a result, the Facility will not be able to appropriately identify and address areas of concern. ▪ The Facility was using some other data sources. For example, the Facility was tracking the timeliness of ISPs, as well as the date the final ISP document was completed and made available for implementation. This data was included in the Self-Assessment. The Facility also had a database to allow aggregation of information related to IDT member meeting attendance, as well as assessment timeliness. This important data also was in the Self-Assessment. ▪ Although some improvement was seen, the Facility did not yet consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Generally, presented findings based on specific, measurable indicators. However, as noted above, at times, it was unclear what criteria had been used. 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 substantial compliance with the following sub-section of Section F: Section F.1.a, related to facilitation of ISPs. This was not consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement. Some improvement was seen in the analysis of this data, and identification of steps that either had been taken or were planned. However, this was not consistent across the subsections for Section F, and, at times, the references to potential reasons for noncompliance and/or proposed corrective action were brief and uninformative.
	Summary of Monitor's Assessment: Since the last review, the Facility Director identified the need for a comprehensive approach to improving Individual Support Plans and set up the ISP Workgroup. After reviewing the Monitoring Team's last report, a group including the Settlement Agreement Coordinator, Qualified Developmental Disabilities Coordinator, the Assistant Director of Programs, and the State Office Program Compliance Coordinator identified a number of areas that crossed disciplines and required attention. At a day-long meeting on 1/17/13 that involved all discipline leads, areas of focus were identified including: 1) assessments (i.e., quality, identifying needed assessments, recommendations related to transition to the community, and timely completion); 2) the ISP meeting (i.e., identifying necessary team members, starting on time, preparation prior to the meeting, draft plans in hand for discussion and finalization, and attendance); 3) documentation following the meeting (i.e., timeliness, complete information, development of good examples of key documents); and 4) plan development and implementation (i.e., meeting implementation timelines, tracking implementation, clinical indicators, and objective development). Action plans were developed for each of these areas, and at the time of the review, they were in various stages of implementation. This was a very positive effort that appeared to be having a beneficial impact in a number of areas. Since the last review, LBSSLC had been provided a significant amount of training and technical assistance

	on the Individual Support Plan process. In April 2013, the State Consultant provided training to all teams on a number of topics related to the ISP process. This included training on goals and the ISP, monthly review, note taking in the ISP, ISP preparation meetings, use of the ISP guide, and the Preferences and Strengths Inventory summary. The State Consultant also had been available to provide technical assistance to three pilot teams. Another consulting group provided training and technical assistance on the Functional Skills Assessment. Discipline Coordinators from State Office also had provided training on the revised Integrated Risk Rating Form and the Integrated Health Care Plans. Three pilot teams had been identified to begin use of the revised ISP format and process. Due to the nature of the work that was done at the ISP Preparation Meetings, which occurred 90 days prior to the ISP meetings, some of the meetings that occurred during the week of the onsite review were the first to benefit fully from the revised processes and staff training. It was anticipated that on 7/15/13, all other teams would roll out the new processes. Although areas needing improvement were seen throughout the ISP development process, some of the areas in which improvements were seen at the time of this most recent review were in the identification of assessments needed for the ISPs and the timeliness of the completion of assessments. Some important preferences of individuals were being identified through the PSI process, but better summary of this information and use of individuals' preferences and strengths in the ISP action plans were needed. Although still a work in progress, more clinical data was being used in the IRRF process, but ISPs still did not include clinical indicators to assist teams moving forward in determining individuals' health and behavioral health status. The scope of actions plans and IHCPs were increasing, but many protections, services, and supports individuals needed were still missing from the plans, and/or were not individualized and/or measurable. The Facility had begun using the revised monthly review format for QDDPs. It was positive that the review process potentially included more data related to skill acquisition plans, as well as review of the other action plans referenced in the ISPs, including the IHCPs. Although deadlines for completion still were not consistently met, timeliness of the monthly reviews had improved. However, concerns continued with regard to the content of the monthly reviews, including the use of data to substantiate status updates, as well as analysis of the data to provide teams with the information necessary to determine if actions needed to be taken to implement the ISP, train staff, or change the ISP or related plans. In addition, more work was needed to involve other team member in the completion of monthly reviews.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual	On November 20, 2012, DADS State Office issued Policy #004.1: Individual Support Plan Process. Comments regarding the policy are included in the subsections to which they apply. The Facility had not yet developed a local policy. DADS State Office recognized the previous ISPs did not meet the requirements of the	

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	shall:	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 revised policy. As noted in the last report, on August 21 and 22, 2012, State Office consultants had provided training on the new process to LBSSLC QDDPs and many team members. Since then various training had occurred, and most recently in April 2013, the State Office Consultant provided additional training to LBSSLC teams. 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 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. This process was again discussed with State Office and Facility staff during the most recent review of LBSSLC, and it was agreed that the Monitoring Team would review four plans for this review, including two plans for individuals whose ISP meetings were held during the week of the onsite review (i.e., Individual #290 and Individual #276), and two that the Facility and State Consultant had selected as being representative of some of the newer plans (i.e., Individual #30 and Individual #242). The State requested more intensive review and commentary on these plans. As a result, in this section of the Monitoring Team's report, a number of examples are provided of both positive changes and areas requiring additional work. These are meant to be examples that are illustrative of overall improvements as well as ongoing concerns. The Facility and State are encouraged to review the examples with the goal of making improvements to the broader ISP development process. As noted in the summary section above, the Facility had developed an ISP Workgroup, and it was in various stages of implementing a number of initiatives to improve the ISP process and the resulting products. Overall, this was a positive development that showed an understanding that the development and implementation of good individualized plans was the responsibility of all team members, and could not be accomplished without the efforts of all involved. These initiatives are discussed in the context of the subsections of the Settlement Agreement to which they apply.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in	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	Noncompliance

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	assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	supports. Positive developments included: ▪ Policy #004.1 in Section II.F.1.b indicated that the QDDP would assist the individual and 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 and reviews of ISPs also illustrated that the QDDP was the team leader and responsible for ensuring team participation. For example, for Individual #290 and Individual #276, the QDDPs led the discussion, assured that team members had opportunities to contribute to the discussion, and followed the guideline for the meeting. ▪ With regard to staffing, since the last review, some changes had occurred. A second QDDP Educator had been hired, and the QDDP Educators now directly supervised the QDDPs. One supervised QDDPs whose caseloads included individuals with more medical complexities, and the other supervised the QDDPS whose caseloads included individuals with more behavioral needs. A QDDP Coordinator oversaw the QDDP Department, and an ISP Technician continued 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 13 QDDPs and two vacant positions. Staff reported that interviews had been held and offers made for the open positions. As of 8/1/13, the Facility expected to be fully staffed with QDDPs. Since the Monitoring Team's last review, eight of the 15 QDDPs had been newly hired. 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 1:15, with a range of 1:11 to 1:19. ▪ As further discussed with regard to Section F.2.e, various training had been provided to QDDPs and team members. In April 2013, the State Consultant provided training on a number of topics related to the ISP process. On 8/15/13, it was anticipated that new QDDPs would undergo Q Construction training. LBSSLC staff had modified the training. They used the training State Office had developed in 2010 and individualized it for LBSSLC. Based on a brief review of the slides for the training, it appeared to be comprehensive and offered a significant amount of important information. ▪ Since the last review, the ISP format had been modified slightly. After the State Consultant provided training to all teams in April 2013, the QDDPs and team members for three pilot teams had begun to use the revised format, and it was anticipated that all teams would begin using the new format on 7/15/13. ▪ The Facility had maintained its Quad Mentoring Groups. These groups were designed to support one another in a number of ways, such as taking typewritten notes at ISP meetings, and covering for one another so that QDDPs could spend an uninterrupted day drafting the final ISP document.	

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		▪ 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. QDDPs generally kept the teams focused on the agenda. For example: ▪ For Individual #290, the QDDP generally did keep the team focused. The guardian, at times, diverted the conversation. He was on the telephone, making it more challenging to refocus him. Other than this, the team remained on track. o Although further improvement was needed, the QDDPs and Nurse Case Managers included valuable information in the draft ISPs and IRRFs, respectively. ▪ Prior to the ISP meeting, Individual #290's team had populated the IRRF with the great majority of the information necessary to have an informed discussion about his risk levels. This facilitated the discussion, and, although the meeting was still long, it was a fairly efficient meeting with a lot of important information discussed, and decisions made. In addition to discussing the risks and related action plans, the team also discussed many other aspects of Individual #290's life. ▪ The QDDPs had provided the teams with draft ISPs. This appeared to assist in facilitating the discussion. An addition to the new format was the inclusion of recommendations from various assessments in the applicable sections of the draft. Although it had not completely resolved the problem, this seemed to help ensure teams discussed the various recommendations. It will be important to ensure that when teams do not accept a recommendations or one recommendation contradicts another that the team discussion reconciling or justifying its decisions are included in the ISP document. o Efforts were made to include the individuals, and focus the discussion on them. For example: ▪ For portions of the meeting, Individual #290 was present. As needed or requested, he left the meeting and returned. The QDDP handled this well, and checked with Individual #290 when it appeared he needed a break, and explained he was welcome to come back whenever he was ready. The guardian was on the telephone and agreed to continue the meeting in the	

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		individual's absence. It was good that the ISP document indicated when the individual was present and when he left the room or returned. o Teams listed the individuals' strengths and preferences, and this information was provided for the team to see. 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 the ISPs observed the week of the onsite review, little to no incorporation occurred of their preferences or strengths into the overall ISP. o The assignment of a QDDP 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 review of the resulting ISPs, they generally were accurately capturing detailed discussion. o Efforts were made to elicit information from all team members. However, not all team members participated to the extent they should have. Some examples of good team involvement included: ▪ Some of the team members for Individual #276 were actively involved in the ISP process and very familiar with the individual. Individual #276's mother was able to attend the meeting via conference call and was frequently asked her opinion regarding team recommendations. The Speech Therapist on the team persisted in asking the team some important questions prompting team discussions. ▪ For Individual #290, a number of team members contributed to different discussions. For example, efforts were included in the ISP to increase his contact with his family. Various team members brought forth ideas about how this could be done, including the use of technology. o Although not consistent across the board, the use of specific clinical data to support risk ratings continued to increase. 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. Although as discussed while on site, it appeared that the revised format of the ISP helped teams to more fully discuss non-risk items by putting them first on the agenda, depending on the individual, it might make sense to have the risk discussion first. 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	

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		of the strategies that were in place or would be put in place to address risks. For example: ▪ For Individual #290 and Individual #276, the teams reviewed and made necessary revisions to the PNMP after the risk rating discussion occurred. ▪ Teams now had draft IHCPs with them during the ISP meetings, as well as drafts of other plans, such as PNMPs, PBSPs, Psychiatric Treatment Plans, etc. It was positive that the drafts were available and formed the basis for the team's discussion. This had been one of the focuses of the ISP Workgroup. o Based on observations, it appeared that team members were coming more prepared to the meetings. For example: ▪ During the ISP meeting, the team for Individual #290 made a number of corrections to the IRRF. These corrections came from many different team members, and showed they had reviewed the draft IRRF. This resulted in a more accurate description of current status and supports. ▪ Individual #276's team had completed the IRRF prior to the ISP as well. ▪ Although work was still needed in this regard, the ISP meetings the Monitoring Team observed were slightly reduced in length from previous recent reviews. And, most importantly, the meetings were more productive than many of those seen previously. As mentioned above, the most recent format for the ISP reversed the order, and had the risk rating discussion at the end. This had a number of pros, because it allowed the teams time at the beginning of the meeting to address the important aspects of the individuals' lives related to living, working, and greater independence. As discussed briefly on site, consideration should be given to individualizing this based on the person's needs, because for some individuals, risk mitigation might be so essential to other components of a person's life that it should be discussed first or in an integrated fashion with the other topics. As part of the ISP Workgroup initiatives as well as State Office training, focus had been placed on the preparation before the meetings. Results were being seen in terms of more meaningful clinical discussions, because a number of team members came with questions prepared that helped to move along the discussion, and identify needed corrections. Although also still a work in progress, action plans were presented in draft format. This allowed team members to review them, and discuss necessary changes and additions at the meetings. Clearly, further improvements were needed with the draft action plans, but the process of bringing a draft seemed to help with the productivity of	

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		the ISP meetings. Based on observations of two meetings held the week of the onsite review and review of ISP documents, 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: ▪ 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 in previous reports, the Facility had been using the Q Construction 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 five of the 15 QDDPs (31%) had successfully completed the competency check-off. However, with the new training and new monitoring tools, this process was likely about to change. In fact, the Facility submitted copies of the LBSSLC Individual Support Plan Meeting Documentation/Monitoring Checklist that had been completed for some QDDPs, but State Office had further modified the monitoring tool for ISP preparation, meetings, and documents. It remained unclear which of the tool(s) would be used to measure competence, and specifically which indicators would be used. At the time of the review, the QDDP Coordinator recognized that more work was needed to ensure all of the QDDPs were competent. ▪ 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. It will be important for QDDPs to ensure the full use of the information gained through the still developing Preferences and Strengths Inventory process. 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. As is discussed in further detail below, even when the team for Individual #290 identified some important strengths, the QDDP did not facilitate their use in then developing action plans to address the individual's areas of need. o Making sure decisions the teams make are data-based to the extent	

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		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. This was an area in which improvement was seen from the last review. A number of the action steps included in the ISP action plans were measurable. However, goals and clinical indicators often were not developed, or when they were, they were not consistently measurable. 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 #290] will be given opportunities each month for his favorite leisure activities on and off campus"), 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. Of note, the Facility found itself in substantial compliance with this subsection of Section F. However, this appeared to be based on the fact that QDDPs were assigned to the task of facilitating team meetings, and did not take into consideration issues related to the quality of QDDPs' role in ensuring "that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports," as the Settlement Agreement requires. Based on the Monitoring Team's review, progress had been made. However, based on observations as well as review of ISPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. In addition, many QDDPs were not competent in meeting facilitation skills. 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	In Section II.A, DADS Policy #004.1 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP,	Noncompliance

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	Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	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 or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. The following summarizes some of the actions taken to address attendance at ISP annual meetings: ▪ Attendance requirements now were determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. The November 2012 updated DADS ISP policy included an attachment (Exhibit A) included some guidance on when particular team members' attendance should be required. The document, which was entitled "Annual ISP Meeting IDT Attendance Indicators," reportedly was helpful to teams at LBSSLC. ▪ After the preparation meetings, QDDPs were responsible for sending an attendance memo that identified the required attendance as well as related assignments. ▪ As part of the ISP Workgroup initiatives, the ISP Technician entered data from the sign-in sheets that allowed comparison of actual attendance with required attendance. Summary data was sent monthly to discipline heads as well as the Assistant Director of Programs. ▪ As part of the ISP Workgroup initiatives, training had been provided to QDDPs on the identification of staff needed in ISP meetings. ▪ The Facility Director set clear expectations that team members identified as required participants in the annual meetings needed to attend. As part of the ISP Workgroup initiatives, all Department Heads and their staff were required to review and sign an ISP Expectations acknowledgement form, which became part of their personnel file. In terms of attendance, the form required employees to acknowledge their commitment to attend ISP meetings as needed, attend on a timely basis, be prepared, turn off cell phones, and stay on topic during the meetings. When concerns were noted they were to be shared with the department head for follow-up, and action taken as needed. In meeting with the members of the Workgroup, they indicated to the Monitoring Team that this appeared to have a positive impact, but acknowledged that some remaining challenges were improving attendance for individuals, LARs, and direct support professionals. The Facility provided data on attendance for the one-year period from April 2012 through April 2013. In response to a recommendation from the Monitoring Team, in October 2012, data was maintained on a number of additional members of the IDT. According to the Facility's data, the average percentage of attendance by required team	

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		members had increased from 74% in April 2012 to 90% in April 2013 (with a range of 63% to 94%). Based on the Facility's data, in the months of February, March, and April 2013, team members whose average rate of attendance was consistently below 90% included individuals, LARs, and direct support professionals. As noted below, one of the concerns about the validity of the data stemmed from the fact that, although improvement was seen, teams were not consistently identifying the appropriate members of the IDT that should be required to attend. Until this is corrected, it will be difficult for the Facility to interpret its data. Based on the sample of four ISPs the Monitoring Team reviewed: ▪ For the four individuals in the sample, at the ISP Preparation Meeting, four teams (100%) defined the members of the team that should attend the annual meeting. ▪ Three of four individuals had strengths, preferences, or needs that potentially required additional team member participation. For none of these three individuals (0%), the team had adequately justified why such team members' participation was not necessary. Those that did not have adequate justification included: Individual #290, Individual #30, and Individual #242. Of note, in identifying team members that needed to be present, the team often used phrases such as "assessment will suffice." This did not provide adequate justification. Justifications were not individualized and did not explain why for this particular individual the team member's attendance was not needed. The specific reasons that an assessment is sufficient need to be provided, or a further explanation of the individual's status or lack of needs in a specific area is necessary. Examples of concerns included: o At the ISP meeting for individual, the PT was not present, and review of the ISP Preparation Meeting documentation showed that the team had not required the PT's attendance. As justification, the team stated: "OT will serve as HT rep." Individual #290 had a number of risk areas related to his physical and nutritional management needs, such as osteoporosis, falls, and fractures. He used a number of pieces of adaptive equipment, including a wheelchair and gait belt, and had a walking program. A PT should have been present, or further justification was needed regarding why an OT could represent the PT. o Individual #30 was blind and required orientation and mobility training, but the team had required that neither the OT nor PT attend. Individual was at high risk for dental, but a representative from the Dental Department was not required to attend. The team provided no justifications for its decisions. o For Individual #242, the team did not require a representative from the	

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		Dental Department, and merely stated: "Assessment will suffice." The individual was rated at high risk for dental, and as discussed below, had refused dental services and had not been fully assessed in over a year. The ISP meeting would have been an opportunity for the team, with input from Dental Department staff, to discuss a plan for moving forward. ▪ For one of four (25%) (i.e., Individual #276), it appeared that a duly constituted team participated in the annual meetings. Individual #276 had all appropriate team members present. For Individual #30, based on the sign-in sheet, missing team members included his LAR (with no explanation provided regarding attempts to include him), day program staff, and a direct support professional. In addition, as noted above, for Individual #30, concerns were noted about the team members invited to attend. For Individual #242, as discussed above, the dentist was not required to attend, but someone from the Dental Department should have attended. In addition, the team had required the attendance of the psychologist and OT, but neither of them were included on the sign-in sheet. The Facility had made progress in that teams were now using the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and had a working system to track and trend the resulting data. However, based on the Monitoring Team's review, the data did not show when teams failed to identify an appropriate team member, and justifications on ISP Preparation Meeting documentation generally were not sufficient to explain why team members supporting the individuals did not need to be present. In addition, although good progress was seen, even when IDTs required attendance of certain members, meetings occurred without the required attendance or explanations provided for excused absences. The Facility remained out of compliance with this provision.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Progress had been made and/or sustained with regard to the conduct of assessments. The status of some of the Facility's efforts included: ▪ The State Office had developed an Assessment/Report Schedule – Minimum Requirements, dated 10/15/12, which was an attachment to the revised policy. ▪ In reviewing a sample of ISPs, individuals' teams had begun to identify necessary assessments at the ISP Preparation Meetings. As noted below, problems were identified with this process, including a lack of justification for assessments related to individuals' specific needs. ▪ As part of the ISP Workgroup, as noted above, Department Heads and their staff were required to sign and ISP Expectations acknowledgement form. Part of this form addressed assessment, including requirements related to clinically correct and appropriate information being included in assessments and updates, ensuring data for risk ratings was included in relevant documents, saving	Noncompliance

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		assessments to shared drives according to established timelines for ongoing assessments as well as during transition planning, including information related to strengths and preferences as well as needs and capacity, and supervisors conducting quality checks of assessments. ▪ To address the issue of timeliness: o The ISP Workgroup noted that when departments had tracking systems and were monitoring this themselves, they generally were the departments that were submitted assessments timely. As a result, all departments were now required to maintain tracking systems. o The ISP Technician also was maintaining the ISP Assessment Tracking Report, and monthly reports were now being shared with Department Heads. Workgroup members reported that these systems had assisted in identifying where problems might lie. For example, discrepancies in the data between the disciplines and the QDDP Department revealed that medical and nursing assessments might have been being completed, but they had not been uploaded to the shared drive. o The ISP Workgroup also required that the data be shared at the QA/QI Council meeting. Based on report, this seemed to have helped to increase timely submission rates. o Better tracking of the completion of the various sections of the IRRF also was a result of the ISP Workgroup's efforts. ▪ In terms of quality of assessments: o The ISP Workgroup had developed a "back page" summary for assessments. Beginning in July 2013, all assessors were to use this page. It listed the individuals' strengths and preferences, identified the tentative goals from the ISP Preparation meeting, and also provided prompts for inclusion of additional needs, strengths and preferences, recommendations, and living option recommendations. As discussed in further detail below, some of the assessments included in the sample of ISPs reviewed included the "back page." This appeared to be a good idea, however, like with anything quality implementation will be essential. Review of some of the initial use of the "back page" showed some concerns in terms of actual integration into the assessment of the information related to strengths and preferences, as well as discrepancies between recommendations included on the back page and those included in other sections of the assessments. o Through the documentation of and discussion about the Workgroup initiatives, the Facility acknowledged that it still had work to do to improve the quality of the assessments. The Facility planned to develop and implement a system to check the assessments for quality. The ISP Workgroup was in the process of identifying for which assessments	

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		quality checks existed and developing checks for those that needed them. For some assessments, checks were currently being completed, but for others this was a work in progress. As identified in other sections of this report some progress had been made with regard to the quality of assessments. However, work still was needed to improve assessments. The Facility provided data on timeliness of assessments for the one-year period from June 2012 through June 2013. According to the Facility's data, the average percentage of timely assessments had increased from 51% in June 2012 to 85% in June 2013 (with a range of 51% to 85%). Based on the Facility's data, in the months of March, April, and June 2013, assessments for which the average rate of timeliness was consistently below 90% included nursing, dental, and the functional skills assessments. Based on review of ISPs, the following concerns were noted: ▪ The quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. The Facility recognized this issue as well, and as noted above, had an action plan as part of the ISP Workgroup to address this issue. However, 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 nursing services (Section M), physical and nutritional supports (Sections O), and vocational, habilitation and skill acquisition (Section S). Some assessments in which some improvements were seen included psychiatry, psychology, and speech and language 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 observations of the ISP meetings during the week of the review and review of documentation, the following provide a few examples of how lack of adequate assessment information stymied the teams' ability to develop and comprehensive ISP: o During the ISP for Individual #276, there was considerable information that was found to be either erroneous or had not been communicated to some of the team members. For example, when discussing information regarding calorie counts, the dietician had not factored in the significant number of calories the individual consumed while at the canteen, making his calorie-restricted diet and calculated daily calories inaccurate. In addition, some of the team members kept referring to a "walking program," however, when researched, the individual was not	

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		on any such program. Consequently, some of the discussions regarding strategies addressing his significant weight issues were not actually occurring. o The IRRF for Individual #276 did not include some very relevant clinical information in order to designate appropriate risk levels. For example, there were no glucose values or ranges included in his risk for diabetes. Also, there were no oxygen saturations listed related to his diagnosis of sleep apnea, significant weight issues, and noncompliance with his Continuous Positive Airway Pressure (CPAP) machine. o In addition, the IHCP for Individual #276 did not include assessments that would be required by the nursing protocols for health issues such as cardiac disease and circulatory issues. o In reviewing the annual medical assessment for Individual #242, dated 3/27/13, the individual had an order for nothing by mouth (NPO), with placement of a feeding-tube. But, in the most current annual medical assessment, under discussion of significant problems, for the diagnosis of oropharyngeal dysphagia, the condition was described as mild and the individual had been prescribed a ground diet texture and nectar thick liquids. The individual had been prescribed Coumadin in the past for a pulmonary embolism, but this had been discontinued by the pulmonologist on 9/5/12. The Active Problem List stated "History pulmonary embolism (2010), on Coumadin," which was not updated to reflect discontinuation of Coumadin. If this list were submitted in a transfer packet to the ER or community, inaccurate information could cause confusion, lead to unnecessary tests and delay in treatment or unnecessary/inappropriate treatment. The current list of medications confirmed the individual was not on Coumadin. However, in the plans and recommendations section of the current annual medical assessment, there was the plan to continue anticoagulation treatment. o It was also noted that the copy of the annual dental summary submitted in the ISP packet for Individual #242 appeared incomplete. This might have had to do with the template used, and such techniques as highlighting might not copy well. However, it appeared such routine information as oral hygiene, behavior, and periodontal condition had no information in the copy submitted. More problematic, as mentioned with regard to Section Q, was the fact that the annual dental summary submitted was dated 4/1/13, but was based on an annual exam dated 9/8/11, which was described as an attempt, with poor behavior. This outdated information likely would not benefit the individual or the team attempting to make current plans and recommendations. ▪ As discussed in previous reports, although since the last review, some limited	

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		improvement was seen, assessments also frequently did not include adequate recommendations. Some of the issues noted included no or limited specific recommendations, or an incomplete list of recommendations; and recommendations not oriented to the development of action plans. ▪ The ISP Workgroup had developed a "back page" for the assessments to ensure they included certain key information, including the individuals' strengths and weaknesses, as well as recommendations, including but not limited to recommendations related to community transition. This was a good idea. However, its implementation was in the beginning stages, and it appeared from review of the small sample of plans that assessors had not implemented this in the way in which it was intended. More specifically, recommendations often were included elsewhere in the assessment reports and not all of them were transferred to the "back page." This resulted, at times, in an inconsistent list of recommendations being included in the ISP sections that now listed recommendations from the various assessments. Overall, it was often difficult to determine from the ISP documents whether or not some of the assessors recommendations were discussed, and if so, why some were implemented and others were not included in action plans (e.g., Individual #276's ISP listed a number of recommendations, but no discussion of them was specifically documented). ▪ Another issue identified was related to the listing of the individuals' strengths and needs in assessments. Although they were now listed on the "back pages," there was little evidence that assessors had incorporated them in meaningful ways in the resulting recommendations. Based on the sample of four ISPs: ▪ For these four individuals, at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for four (100%). ▪ In reviewing the ISPs for four individuals, the teams for four individuals (100%) 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. ▪ For two of the four (50%) (i.e., Individual #30 and Individual #290), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. Examples of issues included: o A number of the assessments Individual #276's team requested were not included in the packet the Facility provided, including assessments from: psychiatry, psychology, dental, rights, and pharmacy. o For Individual #242, a number of the assessments the team identified at the ISP Preparation Meeting were not included in the packet the Facility provided to the Monitoring Team, including, for example, the Aspiration	

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		Pneumonia/Enteral Nutrition Data Sheet (APEN), Structural and Functional Behavior Assessment, and Audiological. In addition, the FSA was not dated, so it could not be determined if it was submitted on time. 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. The individuals included in this limited sample of ISPs all had reviews conducted. They generally had had few incidents with limited apparent patterns, except for one individual who had been involved in peer-to-peer aggression incidents as both a victim and aggressor. For this individual, some limited analysis was completed. On a positive note, the Facility provided a sample of the reports that were now being generated to assist teams in this analysis. A printout was made available to teams listing all of the incidents and allegations with a summary of pertinent information. During future reviews, the Monitoring Team looks forward to reviewing more ISPs that include the teams' resulting analysis of the information to determine whether or not teams have met the goal of 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. Although the Facility remained out of compliance with this provision, some progress had been made with regard to the identification of needed assessments and the timeliness of assessments. In addition, the ISP Workgroup had some plans in place to further address the remaining issues, particularly with regard to the quality of assessments.	
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 ISPs, none of the four 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. ▪ 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 recommendations. As a result, it was not clear what protections,	Noncompliance

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		supports, and services, the assessors had determined the individual required. The assessment results were not translated into recommended action plans, including measurable, functional objectives. As also noted above, although the new "back page" required assessors to include recommendations, for the small number that had been completed, this sometimes resulted in different recommendations being included on the "back page" than in the body of the assessment, and QDDPs had not brought all recommendations forward into the ISP sections that the new ISP format identified. o Although some improvement was seen, 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 and/or to facilitate teams' implementation of the requirements of this subsection: ▪ The ISP Workgroup had included on the assessment "back page" a section in which each discipline was required to make a statement regarding the individual's appropriateness for transition to the community. ▪ Transition Specialists were attending ISP Preparation meetings for individuals for whom a transition might be recommended. They had developed a flier that provided information about their role. ▪ On 11/19/12, the Transition Specialist attended the QDDP Department meeting, and discussed Living Options weekly tours. On 2/21/13, the Admissions Placement Coordinator and Transition Specialist provided training to the QDDPs	Noncompliance

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		on topics such as community tours, the provider fair, obstacles, and monitoring. ▪ QDDPs and other staff had the opportunity to attend the provider fairs. 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. Four individuals' plans were reviewed. The following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the four ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. Those individuals whose assessments did not all include recommendations were Individual #242, Individual #290, and Individual #30. For Individual #276, a number of assessments were missing, so this could not be adequately assessed. This had definitely improved over time, but the ones that sometimes did not include a statement were nursing, day support, dental (who often did not make a specific recommendation, but would state what might be problematic in a community setting, such as the need for IV sedation), functional skills assessments, and recreation. The ISP Workgroup's addition of the assessment "back page" should assist in continuing to improve this piece. o Of the four ISPs reviewed, none of the individuals had been referred for transition to the community. Three individuals' ISPs (75%) included a recommendation from the professionals on the team to the individual and LAR. For Individual #276, the IDT could not reach consensus. Although the template of the ISP indicated that this would require notification of the Facility Director within one day, the ISP document did not specifically state that the team intended to notify the Director. For none of the remaining three individuals (0%) was adequate justification provided for the team's recommendation. The following provide examples of the problems identified: ▪ For Individual #290, the ISP indicated that seven professionals on the team indicated that Individual #290 could be supported in a less restrictive setting, and three did not. Observation of the meeting showed that the team members discussed the reasons for the recommendations against community transition. Of note, this did not appear to be a very informed	

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		discussion, and largely relied on speculation about what was not available in community programs with regard to supports for individuals with active seizure disorders. The QDDP conducted a re-polling of team members, and all those who had originally said he could be supported in a less restrictive setting had changed their minds. Based on observation as well as reviews of the final ISP, specific reasons for their changing their minds were not provided. It appeared that once the team began discussing the possibility of his moving to another SSLC, the option of the community was not given much further consideration. ▪ At the ISP meeting, the professional members of the team recommended that Individual #30 not be referred to the community. However, the differences of opinions in the assessments (i.e., most assessors had said he could be referred for transition) were not explained or reconciled. The team stated: "This determination is based on the recent re-emergence of [Individual's] fecal smearing and urinating on the walls and personal possessions in [Individual's] bedroom. He also has fecal smearing issues while at school... The IDT felt that [Individual] had made progress since coming to the facility but that [Individual] still needed some additional time to completely stabilize... It was agreed that more time was needed in order for [Individual] to have the best chance for successful community integration..." Given that the individual's behaviors that the team described should be able to be addressed in a community setting as effectively as in a large ICF/ID setting, it was unclear what the basis was for the team's recommendation. ▪ Some members of the team for Individual #242 indicated in their assessments that she could be supported in a less restrictive setting and other did not. However, these various opinions were not reconciled in the Living Options discussion as documented in the ISP. The Facility discipline members of the team made the recommendation not to refer her, and indicated: "This determination is made based on her rapid cycling bipolar disorder and having C-diff and VRE [vancomycin-resistant enterococci] in the recent months. The team does not feel [Individual] would benefit from any changes at this time. [Individual] has expressed no preference for living environment but does prefer to be with familiar people that can	

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		anticipate her wants and needs. [Guardian] and sister wants [Individual] to remain at Lubbock SSLC." In addition to this recommendation not being independent of the individual and guardian, it provided no justification for the reasons the Facility staff believed supports could not be provided in the community to support someone with bipolar disorder and infections. ▪ 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 obstacles. In summary, teams were identifying obstacles, but the lists were not consistently complete, including obstacles the team had identified beyond the LAR's choice and/or the identification of the specific reasons for the LAR's choice not to pursue transition to the community. Action plans generally were being developed, but they were not sufficiently individualized and often did not address the all of the perceived obstacles. Although team members generally were including statements in their assessments with regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations most often were not justified. The plans to overcome obstacles to transition were not yet addressing the specific issues related to individuals' and their LARs' reluctance to consider a referral, did not address all perceived obstacles, and were not individualized. The Facility remained out of compliance with this provision.	
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	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	Noncompliance

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	needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	addressed separately below. DADS 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 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; and 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 last report, teams were making efforts to identify individuals' preferences. The Facility was using the Preferences and Strengths Inventory. Based on review of the sample of ISPs: ▪ All four of the ISPs reviewed (100%) included a listing of individuals' preferences and strengths. It was positive that there was some expansion of individuals' preferences beyond items, food, or activities to include routines and interactions with others (e.g., Individual #290 having activities that allowed him to socialize with others). However, some lists were still quite limited (e.g., Individual #242). ▪ Review of the PSIs showed that they were not consistently fully completed (as discussed in further detail with regard to Section S.2). In addition, based on the reviews of the PSIs for the four individuals in this sample, information that was included in the PSIs was not necessarily well summarized, and so key pieces of information that would be important to the teams was not included in the ISP Preparation Meeting documentation or the ISPs. For example, both Individual #242's and Individual #30's PSIs included information that would have been helpful in expanding their opportunities and potentially enhancing their habilitation, but this information was hidden in the PSIs and not summarized well. Some further explanation is provided in the bullet below. ▪ Although some progress was seen, none of the individuals' teams (0%) had effectively incorporated their preferences into related action plans, or used these preferences in creative ways to address individuals' needs (e.g., building in incentives) or to expand individuals' horizons. Although Individual #290's team incorporated his preference for music (which was not formally listed as a preference) into one objective and an objective to "continue Special Olympics" was included, generally his preferences were not incorporated meaningfully. Similarly, for Individual #30, the team addressed his preference for music	

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		through objectives to purchase a radio, and buy music in retail stores, and continued action plans for him to maintain contact with his LAR and other family members. However, little other conspicuous integration of his preferences in the ISP action plans was found. For Individual #242, her team incorporated one of her preferences for having her hair brushed into a SAP designed to increase her communication, and another for lotion rubs in a choice-making objective. However, the list of preferences in her ISP was very short, despite the fact that her PSI included some other preferences that could have been used to increase her participation in activities and expand her horizons. Just as a few examples, her PSI indicated that she liked to listen to books on tape and repeat what was said, she seemed to like cats, and she liked wheelchair exercises and playing bingo. None of these were included in the summary in the ISP. However, all presented options for the team to consider in both increasing her opportunities on campus (e.g., participation in pet therapy or structured day time activities), potentially improving her health (e.g., a formal exercise program), as well as providing opportunities off campus with peers without disabilities (e.g., playing bingo; listening to book readings at a local library, Senior Center, or coffee shop; or volunteering at a animal shelter). Although given her health, some of these might have been longer term goals or her team might have come up with different alternatives, her ISP action plans included a pretty minimal set of active treatment/habilitation objectives that would have been enhanced had her preferences been taken into consideration more. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. Strengths were not regularly built upon to address other need areas. Examples of concerns included: o The discussion of Individual #276's preferences and strengths was very limited and did not emphasize the fact he has the ability to read and write. The team did not integrate either of these skills into his programing or activities during the ISP meeting. o At Individual #290's ISP meeting, his team built upon a fairly basic list of strengths related to tasks that he could complete, and added some strengths related to his qualities, such as his ability to make friends, his happy outlook on life, and his curiosity about new things. Unfortunately, the team did not incorporate any of this information into action plans. For example, a number of these strengths could have been used to address his need for greater involvement in day or vocational activities. o Individual #30's team built upon some progress he had made with orientation and mobility at the public school, and incorporated this strength into a SAP for implementation at the SSLC. However, other clear use of his strengths to address areas of need was not found.	

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		o None of Individual #242's specifically stated strengths were incorporated into action plans or the IHCPs. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of sample ISPs and ISP Preparation Meeting documentation: ▪ None of the plans or ISP Meeting Preparation documentation reviewed (0%) included a list of priority needs. ▪ In none of the plans or ISP Meeting Preparation documentation (0%) was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. Although the ISP Preparation Meeting documentation now included a list of goals the team had decided upon, no explanation was provided of how the team made these decisions. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. ▪ In one of the four ISPs reviewed (25%), barriers were identified, but in none (0%) did the team sufficiently address them. For example, Individual #30's Functional Skills Assessment identified some barriers to community integration, including that he "sleeps too much." Based on review of the ISP document, the team did not discuss or address this issue. In the ISP, Individual #242's team identified her schedule of 20-hour continuous feeding through a feeding tube as the reason for her not attending off-residence day programming. The team indicated that a new feeding pump was on order, and the team would meet again once this equipment was in use. This was good, and showed some efforts to identify and address the barrier. However, what remained unclear was why the team did not define a clear set of activities for her to engage in on a daily basis at the residence to overcome the barrier until the feeding pump was available. She had one-to-one staffing due to protective mechanical restraints for SIB, so this should have been possible. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ None of the four ISPs (0%) reviewed included specific skill acquisition plans for implementation in the community. ▪ Four of four individuals' ISPs (100%) included at least one measurable objective to enhance individuals' general participation and integration into their communities. However, some of these were quite limited (e.g., for Individual #290, the objective was for him to be involved in community activities four times per month, but no detail was provided regarding what such activities might entail and although his team discussed some of his preferences, they were not included in the action plans; and Individual #242's ISP included the	

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		objective: "will attend community activities once per month as her health permits," and as indicated above, her preferences that might have assisted in integrating her into the larger community were not referenced). The following problems continued to exist: ▪ The community-related objectives generally were not written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. Although LBSSLC had made some progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals, in many cases, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. Some of the ISPs reviewed had action plans that addressed community skill acquisition, but they generally did not encourage participation in the community with nondisabled peers.	
	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. Based on the Monitoring Team's observations of two ISP meetings and review of the final ISPs and related documentation and review of two additional recent ISPs, none of the four plans (0%) included a full set of measurable objectives. However, 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: ▪ None of the four 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, some were measurable, but they often were not measurable. For example: ▪ For Individual #290, some of the objectives the team discussed	Noncompliance

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		were measurable and individualized. For example, for Individual #290, an objective was developed for him to "attend community outings 4 times a month over the next 12 months weather permitting." Similarly, a service objective was for the QDDP to "purchases a tablet for [Individual] to Skype on." However, a number of the objectives included in action plans and the IHCP were not measurable. Some examples of action steps that were not measurable included: "will continue to be offered various contracts while at the workshop," or "The QDDP will request information about the… State Supported Living Center in the next 30 days." Generally, the ISP did not define a sufficient day or vocational program or the active treatment/habilitation that would be provided to him during the day. The objective related to obtaining more information about another SSLC did not provide enough information to determine if the task had been completed (i.e., what information was to be obtained). ▪ Similarly, Individual #276 had some action steps/objectives that were measurable and other that were not. For example, some that could not be measured included: "will increase the amount of time he spends on community outings." No baseline was provided, and no specific goal was set by which to measure progress. ▪ Individual #30 had a number of action steps that were measurable. However, a number were not. Some examples included: "[Individual] will follow up in Neuro clinic for seizure disorder," with a timeframe of "ongoing;" or "Staff will continue current PBSP in place to maximize positive behavior and maintain health status." o When supports were identified, they often were not individualized. For example: ▪ The IHCPs for Individual #290 included a number of action steps referring to nursing protocols without any individualization. For example, he had an action step in his IHCP that read: "Nursing staff will follow seizure protocol if [Individual #290] displays seizure activity." This was unhelpful, particularly given that he had an active seizure disorder. With regard to nursing protocol, this was fairly consistent across all of the plans reviewed. The only exception was some of the plans for Individual #242, and even for her, there was limited individualization of the nursing protocols.	

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		▪ As noted above, the action plans for community participation, education related to community options, as well as day program/vocational activities generally lacked individualization. Many appeared to be stock objectives/action steps that were repeated from ISP to ISP. 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: ▪ Skill acquisition plans generally were identified in the ISP action plans, as well as some objectives to assist individuals to maintain or increase contact with family members. These often were measurable. However, it appeared some standard types of objectives were being used (e.g., sending cards, participating in generic community activities, etc.), and little creativity or individualization was noted. ▪ The team for Individual #276 essentially added no measurable interventions addressing his weight that was 139 pounds over his desired weight range with a BMI of 50. ▪ The IRRF for Individual #290 included a number of important "current supports." However, the team did not verbally at the ISP meeting or in the final version of the ISP include these in the action plans or in IHCPs. As a result, the IHCP was missing many important supports. Of additional concern was the lack of inclusion of supports identified for areas of low risk. Although the IHCP has been designated as the document in which medium and high risks will be identified, the ISP still needs to include the supports for low risks and/or other health issues that are not included on the IRRF. ▪ Similarly, for Individual #290, the action step the team discussed and included in the IRRF for the PCP to order and review current calcium levels to further inform orders related to calcium supplements was not included in the IHCP. ▪ For Individual #290, in the IHCP, the team did not focus on a number of important preventative actions beyond medications or the implementation of plans (e.g., the PNMP). For example, for constipation, the IHCP only included two action steps including direct support professionals documenting his bowel habits and reporting triggers to nursing staff, and nurses following the "nursing protocol" for constipation if he did not have a bowel movement in three days. None of this was preventative (e.g., assisting him to exercise, making sure he had	

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		access to and drank fluids, etc.). ▪ Individual #30 was at high risk for dental. He had "poor" oral hygiene. He had a SAP for tooth brushing as a desensitization program related to the use of general anesthesia, and his IHCP only addressed his safety around the use of general anesthesia. Beyond these supports, no supports were identified to address his poor oral hygiene, and no measurable objective was included to measure the success of the team's interventions (e.g., he would improve his oral hygiene to a "fair" rating within the next year). ▪ 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 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 consistently 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. Examples of concerns included: o Individual #242's IHCPs were some of the more extensive ones the Monitoring Team has seen thus far. They included a number of important action steps. However, although the team was on the right track, significantly more work was needed to ensure they both included the necessary action steps and included the measurable clinical indicators necessary to assist the team to determine whether or not the individual was doing better or worse, or remaining the same as compared with baseline or desired measurements. The following provide just a few examples from Individual #242's IHCPs: ▪ Most of the "goals" included in the IHCP were not goals, but lists of supports that should have been provided. Sometimes, the IHCP went on to list some of the supports in the action plans, but not always. One example of this was the "goal" for the risk factors of choking, aspiration, respiratory compromise, etc., which read: "[Individual] will be provided with appropriate supports: Proper positioning per PNMP, NPO [nothing by mouth] w/all supplementation and medications via Feeding tube. Aspiration trigger sheets, hospital bed HOB [Head of Bed]	

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		elevation abdominal binder, and level of supervision of 1:1 24 [hours]/day. Hand held nebulizers w/Albuterol as needed, and suction toothbrushing TID [three times a day] to aid in prevention of choking, aspiration, and respiratory compromise AEB [as evidenced by] clear lung sounds upon auscultation, proper positioning per PNMP, appropriate documentation and appropriate medications." This did not include a clinical indicator(s) to provide the team with information about the individual's status. It was positive that some of the action steps included maintenance and review of trigger sheets, reporting of emesis, reporting of certain events to the PNMT, checking of residuals before feeding and TID, checking of tube placement, and documentation and review of bowel management records. However, in addition to problems noted with a number of these actions steps (as discussed in other subsections of Section F), none of them were designed to provide the team with a snapshot of the individual's status (i.e., a clinical indicator). For example, two of the action steps revolved around oxygen saturation rates. Although it was unclear how often oxygen saturation rates needed to be measured (e.g., each shift, each day, at specific times of day, or before or after certain activities), no clinical indicator had been developed with a goal expressing what the parameters of the rates should be. In other words, when monthly reviews (or more frequent reviews, depending on the needs of the individual) were conducted, the clinical indicator should tell the team when they should be concerned. For example, for this individual, it was unclear at what point based on the analysis of ongoing oxygen saturation rates, the team would need to reevaluate the supports. ▪ As another example of concerns related to the lack of clinical indicators, Individual #242 had a serious and active psychiatric diagnosis of bipolar disorder. Based on the IHCP, the "goal" was "[Individual] will receive an effective PBSP, medication regimen, medication monitoring AEB no serious injuries [related to] seizure activity/behaviors, and stable medication levels." A serious injury should not need to occur in order for the team to know that the current supports are not working. Although the ISP and IHCP referenced the PBSP and Psychiatric Treatment Plan, no clinical indictors from these plans were included in the IHCP. Similarly, for this individual, no clinical indicator had been developed to provide the team with a	

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		picture of whether or not her seizure disorder was well controlled. Again, serious injury is not the only outcome that would be expected for an individual with a seizure disorder. o The IHCPs for Individual #290 did not include measurable clinical indicators to determine if the individual was remaining stable, improving, or experiencing negative healthcare outcomes. For example, for Individual #290, the goal for his risk areas of Seizures and Polypharmacy read: "To help prevent complications related to poly-pharmacy, and to prevent injury related to seizure activity AS EVIDENCED BY providing the supports identified and action plans listed below." This provided the team with no mechanism to determine if the "supports identified and action plans" were working. This was an individual with an active seizure disorder. The team could have instead developed a measurable clinical indicator related to the reduction of seizures to a specific number (e.g., from 50 seizures this year to a specific number over the next year), or the duration of the seizures, etc. Without such an individualized clinical indicator, the team could not accurately measure over time whether or not the supports were working, or needed to be modified. o The IHCP for Individual #276 included some measurable action steps, such as one that provided the parameters for his blood sugar. Although it was unclear what steps nursing staff were to take if it went outside the parameters, it was positive that this objective was stated in more measurable terms. However, action steps such as the following were not measurable and were not helpful to the team in determining if supports were being implemented and/or were effective: "DSP will encourage [Individual] to use his CPAP machine while sleeping and encourage [Individual] to sleep on his side," or "The RN Case Manager and Dietician will monitor weights monthly and intervene as necessary." Given that Individual #276 was considered "extremely obese" according to his ISP, it was unclear what was meant by "intervene as necessary." o Individual #30's IHCP included some goals related to his risk areas, but they were not particularly helpful in assisting the team to determine if his supports were effective, or if they needed to be changed. For example, one of his goals was: "[Individual's] behavioral health will be monitored and interventions taken as needed to maximize positive behaviors and maintain health status." Although he had a PBSP and a psychiatric treatment plan, measurable goals from these plans were not included in his IHCPs. ▪ 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	

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		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. Based on observations of two ISP meetings on site and review of four ISPs, 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;	Based on observations of meetings and team discussions and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ More inclusion was seen in the ISPs of the psychiatric, counseling, habilitation therapy, PBSPs, and nursing care, but a number of concerns were still noted. Positive examples included: o In discussing risk areas, the team made recommendations for changes to Individual #290's and Individual #242's PNMPs. These changes were confirmed during the meetings, and the teams approved the "revised" PNMPs. o For Individual #242, the team reviewed the PNMP (as noted above), as well as the PBSP, Psychiatric Treatment Plan, and Protective Mechanical Restraint Plan. This was positive, and it appeared that the team also discussed and weighed the risks versus the benefits of the latter two plans. However, as noted below, a number of issues were noted with regard to the integration of this information into the IHCPs. o Based on discussion with ISP Workgroup members, it was now the expectation that team members would come to ISP meetings with draft clinical and treatment plans to assist teams in discussing the plans at the meetings and making changes as needed. Examples of concerns included: o During Individual #290's ISP meeting, reference was made to a walking program that PT oversaw. The team discussed the need for Individual #290 to have more opportunities to walk using his gait belt. However, neither the walking program, nor a methodology for increasing the times he was walking with staff assistance were integrated into the action plans or IHCPs. o Similarly, Individual #290 had a number of medical concerns, including an active seizure disorder. In fact, the team made the decision not to refer him to the community based on their conclusion that his medical	Noncompliance

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		needs were too significant. However, except for having a DEXA scan every two years and attendance at allergist appointments, his IHCPs did not include medical supports. The nursing supports that were included were generic, and not individualized, or they involved administering prescribed medication. o Several members of Individual #276's IDT members were concerned about referring him to the community due to his reportedly significantly aggressive behaviors. Of note, no behavioral data was included in the ISP or IRRF. In the IRRF, overall statements were made, such as he experienced and "overall reduction" in behaviors over the last year. This was unhelpful and did not allow the team to obtain an objective picture of his status. Moreover, the IHCP did not include measurable objectives related to the PBSP, but rather stated: "DSP to follow [Individual's] PBSP." This data, as well as measurable objectives were included in the PBSP the Facility provided to the Monitoring Team. So, it was unclear why they had not been included in the IRRF and IHCP to integrate the PBSP into the overall ISP. Similarly, Individual #276 had a psychiatric treatment plan, but limited information was provided on his psychiatric status in the IRRF, and the goal/objectives of the psychiatric treatment plan were not included in the IHCP. Rather, the objective included stated: "[Individual] will receive annual psychiatric clinic evaluations." o Individual #242's ISP made reference to an "abdominal binder for prevention of pulling at Feeding tube." Although the IHCP included reference to the "protective mechanical restraint for SIB [Self-injurious Behavior] checklist," no plan was found in the action plans or IHCPs for strategies to reduce to the extent possible the use of this procedure. Similarly, the PBSP and Psychiatric Treatment Plans, although discussed in the ISP document, were not included in any measurable way in the IHCPs. For example, the measurable objectives of these plans were not included as action steps in the IHCP. Similarly, a number of Individual #242's medical plan components were not included in the IHCPs. ▪ Delineation was not sufficiently clear of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.). The focus tended to be on implementation, and other areas often were missing or not well defined. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. ▪ The ISP action plans and IHCPs did not consistently include the supports that the team identified in the IRRF or elsewhere in the ISP. For example: o The text of the ISP indicated that the SLP at Lubbock would upgrade	

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		Individual #30's alternative and augmentative communication device to be consistent with the one at school. Once a revised device was available, consideration of a skill acquisition program also was mentioned. This was important, given that reportedly he was using his AAC device "to request things at school that he still uses hand gestures to request on the home [sic]." However, revision of his AAC device and potential modification of the SAP were not included as an action step with timeframes for completion. Similarly, coordination with a local university on mobility training was discussed. Although a SAP was included to increase his use of his cane outside, no action steps were included in relation to coordinating these activities with the group teaching him these skills at school. o The text of Individual #242's ISP indicated that direct support professionals would begin collecting data about her behavior at bath time and how many times she was redirected from pulling at the feeding tube. However, this was not included in the IHCP as a support that would be provided. Similarly, the text of her ISP indicated that triggers for her manic phases would be tracked so that direct support professionals could "call for her medication outlined in her psychiatric medication plan," but this was not included as an action step/support in her IHCP. The text of Individual #242's ISP discussed the communication supports that the SLP had identified would be beneficial for her. Although it appeared that the team agreed that some specific techniques, including but not limited to the use of "All Served" communication equipment, use of her communication dictionary, and rewarding of all of her attempts to communicate, the only reference to these strategies in the action plan or IHCPs were SAPs for making choices and answering staff when they asked if she wanted her hair brushed. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. Previous reports have provided details about what was missing. However, some examples include: o One of the ISP action plans for Individual #276 was: "[Individual] will work on new skills that will help him with obtaining a new job in the community or within the Facility." The methodology/action steps for attaining the goal were weak. It included continuing to work at the work center, continuing to work in Supported Employment, having vocational staff implement his PBSP while at work, "reinforce" him for work he completes, and a SAP that read: "will remain on task 1 out of 1 trial for 16 data taking sessions without prompt." It was unclear why the team thought that this set of action steps would was sufficient to	

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		assist Individual #276 in achieving the stated outcome. None of the four plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, including the IHCPs, this was in its beginning stages of implementation. Some improvements were seen. However, as noted above, 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;	The following findings are based on reviews of the sample of ISPs: ▪ For none of the four ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the four ISPs (0%), the roles of the persons identified as responsible were clearly defined. The following summarizes some of the problems noted: ▪ At times, the "IDT" was identified as responsible for reviewing efficacy of the IHCPs (e.g., for Individual #290). This made everyone responsible, and no one responsible, increasing the likelihood that it would not occur. This made it unclear who would be responsible for monthly reviews, and/or notifying the team of the need to meet if plans were not effective. ▪ Often two positions were identified as responsible for the completion of the same action step, but it was not clear who was responsible for what. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. It will be important, though, as discussed elsewhere to ensure that their roles are clearly defined, as well as the methodologies they should use to implement action steps. For example, as noted above, when direct support professionals and supervisory or clinical staff were listed as both being responsible for the same action steps, definition was needed of for what the direct support professionals were specifically responsible as opposed to clinical staff. ▪ Although some improvement was seen, some problems continued in relation to timeframes. For example: o For Individual #30 and for Individual #242, the term "ongoing" was used for many of the supports, even when it appeared that a certain frequency would be expected. For example, for Individual #30, neurological clinic visits likely had some expected frequency, but the timeframe was listed as "ongoing." Similarly, it would be expected that	Noncompliance

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		the RN Case Manager would review the seizure log at a certain frequency, and provide the team with a report on the efficacy of the treatment at certain intervals. However, these activities were listed as "ongoing." With regard to methodologies in action plans: ▪ In none of the four plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although more of the methodology was included than seen during past reviews, steps were often missing. A few examples of missing methodologies included: o For Individual #276, a few of the action steps for which methodologies were not apparent were: "Vocational staff will reinforce [Individual] for his work that he completes," or "[Individual] will be encouraged by all to use his all served communication devices to express his needs and wants within the next 12 months." o As noted above, sometimes methodology was included in the IRRFs for addressing at-risk issues, but the ISPs did not include action plans with the necessary detail. ▪ In addition, as is discussed with regard to Section I, action plans for individuals, identified as being at risk, frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The IHCPs set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. 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 for the various steps required to complete the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Although all of the plans included some practical and functional interventions, none of the four reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals at-risk, nursing care plans, PNMPs, OT and PT direct therapy plans, communication plans, and PBSPs. An area in which some improvements continued to be made was in developing supports and services that were practical and functional in the community. Although as discussed	Noncompliance

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		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. In the ISPs the Monitoring Team observed, teams identified a mix of functional and nonfunctional objectives. For example: ▪ Individual #30's team identified a number of functional skill acquisition programs, including, for example, learning to use a cane for outdoor orientation and mobility, using coins to make a purchase from a vending machine, and washing his hands. ▪ For Individual #290, the team developed a number of functional objectives (e.g., washing his hands based on his tendency to touch many objects in his environment, using a button to turn on his radio, and cleaning the table top). As noted elsewhere, however, although the team recognized that his attendance at work/day program needed improvement, the team did not focus on developing action plans or objectives that would increase his ability to participate in functional activities throughout the day, thereby potentially increasing his skills as well as his interest in participating in activities. ▪ For Individual #276, the team developed a number of functional objectives (e.g., checking his blood sugars, and using a calendar to track appointments). However, others were not as functional (e.g., learning to distinguish between coins had no functional outcome, and given that he was regressing on his progress, it was unclear why the team did not develop a more functional alternative). In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Access to food was limited. So as was seen for one individual that recently tried to transition to the community, free access to food in a kitchen in a small group home became quite problematic. The ISP also identified this as a potential issue in transitioning to the community for Individual #276. Similarly, individuals generally did not have objectives related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at LBSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when	

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		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 the review of the sample of ISPs: ▪ Although some improvements were seen with regard to teams' use of data, none of the four ISPs reviewed (0%) appeared to be driven by a review of objective data for each of the related action plans, and the presence or lack of progress on measurable objectives and outcomes. For example: o Although Individual #290's team discussed his previous goals and objectives, specific data generally were not discussed, particularly with regard to skill acquisition programs. As just one example, in discussing a SAP related to throwing away his cup after medication administration, the team concluded: "[Individual] has almost mastered this skill." The SAP was discontinued without the team discussing any objective data. As discussed with regard to Section I, his team used data in discussing risks. However, the team had not yet developed clinical indicators to allow comparison over time of his risk status. o Similarly, when Individual #276's team reviewed his SAPs from the previous year, global statements were made with regard to regression on certain goals with no specific data provided. In reviewing ISPs, often the action steps in the IHCPs identified the frequency of data collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. This varied, but generally, in the IHCPs reviewed, in the column for "Persons Responsible for Reviewing Progress and Effectiveness & Frequency of Review," the Persons Responsible were identified, but not the "Frequency of Review." As a couple of examples: ▪ For Individual #290, although the frequency was often noted for monitoring in the IHCPs, this did not occur consistently throughout the plans. An overriding concern with these IHCPs was the use of the term "IDT" as the entity responsible for the review of the efficacy of the plan. Timeframes for monitoring also were confused with timeframes for documentation. For example, for the action step that read: "DSP will follow Dietary Recommendations and Dining Plan," it was unclear what the RC's and RN Case Manager's roles were specifically, and what was meant in the "Monitoring Frequency and Location of Documentation	Noncompliance

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		column" by "During every meal and snack; PNMP data sheet." ▪ For Individual #276, timeframes for monitoring frequency and review of efficacy generally were not stated, and often more than one person was identified as responsible for review of efficacy without delineation of specific responsibilities. The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., goals/objectives related to integrated health care plans, psychiatric treatment plans, PBSPs, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Although teams discussed data in the context of the IRRF, the data available on the IRRFs varied in quality and comprehensiveness. This is discussed in further detail with regard to Section I. Of ongoing concern was the lack of data presented in the ISP and/or IRRF in relation to SAPs, behavioral health plans (i.e., PBSPs, psychiatric treatment plans, and counseling plans), as well as direct therapy plans. Since the last review, improvement continued to be seen with regard to data being used to inform some of the at-risk discussions. However, 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. The Facility remained in noncompliance with this requirement.	
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 observations of ISP meetings and review of ISPs, this was an area in which some improvement was seen, but more was needed. 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; 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. For example: ▪ Based on observation of Individual #290's ISP meeting, the team discussed his communication, and many team members provided input into what would work best. However, more work was needed to ensure adequate collaboration and coordination between team members. The following provide an example of where opportunities for integration were missed resulting in an individual's ISPs not reflecting a comprehensive	Noncompliance

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		set of services and supports: ▪ During the discussion about polypharmacy, the team for Individual #290 stated: "no side effects noted" for the five seizure medications and three medications for allergies. However, earlier in the team's deliberations, the team had expressed concern that he slept throughout his workday. Although there could be many reasons for his sleeping (e.g., bored with activities, not getting enough sleep, etc.), the team did not discuss the possible reasons, and particularly his medication regimen. This would have been an opportunity for a number of different disciplines to share their expertise to identify supports that might benefit Individual #290, and result in better outcomes for him.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.1 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. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. LBSSLC had begun to run a sample of ISPs through a program to determine readability level. Based on the Facility's sample of 12 ISPs, 50% of them met the fourth to fifth grade reading level. Another issue related to comprehensibility of the ISPs reviewed was the lack of delineation of responsibility for the implementation of the plan. Although as noted above, the role of direct support professionals was becoming better defined, this in large part was due to the fact that the ISPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports (e.g., "encourage" and other similar terms would be difficult to implement). After training from an external consulting agency, in April 2013, the Facility implemented a Reference Sheet for all individuals. This provided a snapshot of some of the most	Noncompliance

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		important facts for direct support professionals to know about individuals. For example, some of the information included the individual's allergies, adaptive equipment, special considerations, likes, dislikes, goals, a summary of the PBSP and target behaviors, and a variety of preferred activities. This quick reference should be helpful to direct support professionals. The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily understood terminology.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III.A addressed individual support plan monitoring. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. It required that within 10 calendar days after the end of the review period, the monthly reports would be filed in the individual's record. Given that the review of ISPs for this review was limited to some of the most recently developed ISPs, monthly review information was not available/reviewed for the sample of four individuals whose ISPs were reviewed. However, the Facility Monthly Review tracking log data, and for Section S.1, a sample of monthly reports was reviewed. In addition, in the Presentation Book for Section F, in relation to Section F.2.a.4, the Facility provided information on monthly reviews. Findings from the review of these documents are provided below. Based on interview and information in the Presentation Book for Section F, in February 2013, the QDDP Monthly Review Instructions were revised. LBSSLC chose to add the optional graphs to the reports. QDDPs were trained on the Monthly Reviews on 4/23/13. The ISP Technician was responsible for tracking the completion of monthly reviews in the Monthly Review tracking log. With the updated instructions, action plans were included in the monthly reviews. Based on staff report and review of some sample monthly reviews in the Presentation Book, IHCPs were supposed to be included, and at LBSSLC, they were included in some, but not all, of the monthly reviews. Staff reported that eventually, the goal was to have the draft monthly report housed in a place where other team members could access it and add information related to the programs/action plans for which they were responsible. Currently, the QDDPs had to go back through Integrated Progress Notes (IPNs) and other documentation to determine the status of various action plans, including IHCPs. In terms of timeliness, based on the Monthly Review tracking log data that the Facility had updated through the May 2013 monthly reviews (i.e., those that should have been completed in June/early July), in reviewing the last three months of data, the data showed that generally, the monthly reviews were being completed. Based on the 10-	Noncompliance

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		calendar day timeline specified in the DADS policy, problems continued to be noted with timeliness. More specifically, based on ISP dates and dates of the monthly reviews, the reviews were not consistently dated within 10 calendar days of the end of the review period, and likely additional lag time occurred in filing the reports. However, timeliness appeared to be improving. As noted with regard to Section S.1, review of 14 individuals' monthly review reports showed problems with the timeliness as well as the quality of the reviews. For example, not all of the skill acquisition programs in individuals' ISPs were reviewed, data was not specifically cited to substantiate whether or not progress had been made, or a review/summary was not provided due to the inadequacy or lack of raw data. In addition, in some cases, when data was described in the monthly note, it did not appear consistent with the actual raw data sheet. Graphs were provided in very few monthly reports, but the graphic displays were not necessarily useful, because the titles on the graphs were vague and the graphs themselves (including the data) were un-interpretable. Based on review of the samples included in the Presentation Book, similar issues as described with the SAP data were found with regard to the action plans and IHCP reviews. Overall, the monthly reviews provided little information to the teams regarding whether the individual was doing better or worse, remaining stable, and/or whether or not the team needed to take action. In part, the problems stemmed from the lack of sufficient action steps/measurable outcomes in the ISPs, but the quality of the reviews QDDPs and/or other team members completed also contributed to the issues with the adequacy of the reports. A couple of examples to illustrate the concerns follow: ▪ Individual #314's IHCPs were reviewed in the monthly review report. However, very little, if any, helpful information was included in the monthly review dated 6/19/13. The monthly review/summary column stated: "Continues as written" for all of the steps in the action plan. Only two of the eight steps from the IHCP included additional information, and this was just the addition of dates on which the quarterly drug regimen review and MOSES were completed. This provided the team no information regarding the individual's status regarding his medium and high-risk areas, making it difficult to determine whether further action was needed. This was an example that illustrated the problems with how some of the action steps were written, but also showed a misunderstanding of the intent of a monthly review. For example, one of the action steps was: "The DSP will document on [Individual's] Bowel Management Record daily (report no BMR [sic] in 3 days to nursing immediately)." The summary "Continues as written" provided no meaningful information. It did not answer questions about whether or not daily documentation was present, and whether or not the nurse had had to be contacted, and if so, if DSPs did contact the nurse and what happened. This	

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		fuller analysis would provide the team with information necessary to determine whether or not action was needed to address concerns related to constipation, or whether the current supports (which were not specified in the IHCP) were effective. ▪ Although the monthly review for Individual #82 provided more information, the information remained limited and not necessarily helpful in determining where action might be needed. Specific data was not included for a number of action steps for which it would be helpful. For example, she had an action step to "continue work at the … workshop." The summary indicated she "attends work regularly as scheduled." It was not clear what "regularly" meant. Attendance data would have been helpful. The only reference to her IHCPs was a statement that: "[Individual's] Integrated Health Care Plan is completed and on her chart [sic]." No details were provided to assist her team in determining if action needed to be taken, or if her health care indicators for her at-risk areas were stable or improving. In terms of follow-up to identified concerns, as noted above, it was not clear that concerns were being identified, but even when they were, action steps were not consistently identified to address the issues. For example, for Individual #314, multiple refusals were identified for five of his SAPs, calling into question whether or not he was receiving adequate active treatment/habilitation. However, the QDDP concluded: "[Individual] had a good month, no concerns at this time. Will continue to monitor monthly." Clearly, the goal of a monthly review is to identify issues, and correct them quickly. Moreover, with regard to "significant changes in status," as discussed in various sections of this report, individuals that were hospitalized were reviewed at the morning provider meeting, and often ISPAs were developed. This was a positive change, and the details of these reviews are discussed with regard to Sections G.1 and L.1. However, other significant changes in status occur, and without good clinical indicators embedded in ISPs, it will be difficult for teams to properly react, including meeting to make changes to the ISPs, including IHCPs. Of note, as part of the ISP Workgroup initiatives, further clarification had been provided to teams regarding when ISPA should be developed for individuals. Generally, the summary of when ISPAs were needed seemed to be a helpful document that pulled together many of the requirements of various DADS policy as well as the Settlement Agreement. As noted above, broad topics such as changes in status and areas in which progress is not being made will require teams to have good measurable indicators and goals/objectives by which to judge when such criteria have been met.	

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		Some progress had been made in incorporating more of the action plans into the QDDPs' monthly reviews, including to some extent review of IHCPs. However, the Facility recognized that QDDPs could not do this without more involvement of other team members. In addition, QDDPs needed to include more data and analysis of information in their reviews. 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.	In previous reports, the Monitoring Team has provided details regarding the training provided to QDDPs and other team members on ISP development. The following provides an update on the training related to the ISP process that had been provided to staff since the Monitoring Team's last review: ▪ On March 18, 2013, the QDDPs, as well as the Active Treatment Coordinators, and SAP Developers participated in an in-service with the State Office Consultant that covered a number of topics related to the ISP development and implementation processes. The processes related to the ISP Workgroups initiatives, such as the use of the "back page" for assessments were covered in this in-service training ▪ In April 2013, the State Consultant provided training on a number of topics related to the ISP process. This included training on goals and the ISP, monthly review, note taking in the ISP, ISP preparation meetings, use of the ISP guide, and the preferences, strengths, and inventory summary. Another consulting group provided training on the functional skills assessment. ▪ As noted in the last report, in September 2012, the Supporting Visions: Person-Centered Planning curriculum used at New Employee Orientation (NEO) was updated. On 2/7/13, QDDPs began assisting with New Hire Supporting Visions Training; ▪ On 8/15/13, it was anticipated that new QDDPs would undergo Q Construction training. LBSSLC staff had modified the training. They used the training State Office had developed in 2010 and individualized it for LBSSLC. Based on a brief review of the slides for the training, it appeared to be comprehensive and offered a significant amount of important information. ▪ As noted in previous reports, 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. 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 substantial compliance with the Settlement Agreement included:	Noncompliance

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		▪ 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 in previous reports, the Facility had been using the Q Construction 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 five of the 15 QDDPs had successfully completed the competency check-off. However, with the new training and new monitoring tools, this process was likely about to change. At the time of the review, the QDDP Coordinator recognized that more work was needed to ensure all of the QDDPs were competent. ▪ The Facility had not yet begun to implement competency-based measures for the writing of ISPs. However, the plan was to use the new Section F monitoring tool for facilitation competency, as well as ISP writing. From this tool, it will be important for specific competency measures to be identified in relation to the writing of ISPs (as well as facilitation). It also will be important to clearly define the process, including what will happen if some QDDPs are not able to meet the competency requirements. ▪ 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 and/or technical assistance 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), although some progress had been made, particularly with regard to foundational skills for PNMPs as well as BSPs, adequate processes were not in place and/or not yet fully implemented to ensure that staff had successfully completed competency-based training on the implementation of components of the ISPs, such as individual-specific behavior support plans, individual-specific physical	

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		and nutritional management plans, indirect therapy plans, use of alternative and augmentative communication, and/or skill acquisition plans. According to the action plan submitted for Section F.2.e, a plan was in place to train staff on ISP Reference Sheets, and then monitor to ensure staff competency. A process was defined in the action plan for the QDDP Department to work with Residential Services management staff to correct deficiencies, as well as to provide positive feedback when staff demonstrated competence. In addition to the efforts underway with regard to PBSPs and PNMPs, this should be helpful in increasing staff's competence and adherence to the plans referenced in ISPs. 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 development of action plans, 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 often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on data the Facility provided, between 11/15/12 and 5/15/13, nine individuals had been admitted to the Facility. All nine individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 221 ISP meetings were held between 4/15/12 and 4/15/13. Seventeen ISP meetings occurred more than 365 days after the previous annual meeting. The Facility indicated all of these meetings were scheduled within the 365-day timeframe, but various circumstances arose that require them to be postponed. The Facility Director had approved each of the extensions. In the Presentation Book for Section F, the Facility provided a copy of the 2013 ISP Extension Memo Tracking. It showed in 2013, five extensions had been requested. They all had been necessary to accommodate guardians' schedules. They all were appropriate, given the importance of guardian participation in the ISP process. The Facility also provided some examples of memos showing the Facility Director's approval of these requests. A number of steps had been taken to facilitate the completion of the ISP documents within 30 days. This included QDDPs developing draft ISPs before the meetings. In addition, the Facility had assigned QDDP typists for each ISP meeting. The QDDP typist attended the ISP meeting, and took notes and/or made changes to the draft ISP. This assisted the QDDP running the meeting, and resulted in a more complete draft of the ISP at the end of the meeting. The State's Consultants had included tips on taking notes during ISP meetings as part of their training. After the ISP meeting, the QDDP took a pre-	Noncompliance

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		assigned "ghost" day and spent time finalizing the ISP, while another QDDP provided "ghost day coverage" by addressing any issues that came up on the QDDP's caseload. These steps appeared to be having a positive impact. Based on data the Facility provided, for the 221 ISP meetings held between 4/15/12 and 4/15/13, 103 (47%) were filed within 30 days after the ISP meeting. The Facility also provided monthly data for the months between November 2012 and May 2013. During these months, the range of compliance with the 30-day completion rate for ISPs was between 38% in December 2013 and 94% in May 2013. One of the factors that Facility staff indicated had resulted in some months of low compliance was the high turnover in QDDP staff, particularly around December and January. Facility staff recognized that for the ISP to be "put into effect" within 30 days, the ISP needed to be completed and filed, but actions also were needed to ensure it was being implemented. This was one of the focuses of the ISP Workgroup. The Facility had begun to take some other steps to ensure staff were trained on the individuals' ISPs. Specifically, once the ISP was completed, the ISP Technician sent the ISP to the Residential Coordinator who was responsible for completing competency-based training with staff. The signature sheets were sent back to the ISP Technician for tracking. At the time of the Monitoring Team's onsite review, this was fairly new, but it was a promising practice. The Residential Coordinators also were responsible for tracking the training of staff on the Skill Acquisition Plans. QDDPs were responsible for placing the action plans in Individual Notebooks. The Competency Training Department was assisting in tracking training, particularly for PBSPs and PNMPs. A step that was in process at the time of the review was developing a mechanism to determine who had not been trained, so that training could occur. CTD had hired a Clerk to assist with the data entry required, and it was anticipated that exception reports would be available soon. The Facility remained out of compliance with this provision. However, progress was noted, and the Facility continued to pursue 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 full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and	Progress had been sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement. Positive aspects of the process included: ▪ DADS Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of	Noncompliance

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	remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	the Settlement Agreement. ▪ A Program Compliance Monitor (PCM) from the QA Department, and the QDDP Coordinator were conducting the reviews. At the time of the review, the PCM selected a sample of approximately 20% of the ISP meetings per month. The process had changed to include observation of the ISP Preparation Meeting, the ISP meeting, and then review of the final ISP document. ▪ As noted in other subsections of this report, the Facility also had mechanisms in place to collect other relevant data, such as the timeliness of the submission of assessments, and attendance at ISP meetings. ▪ The PCM and QDDP Coordinator met approximately monthly to review the results of monitoring activities, and maintained minutes. ▪ As noted elsewhere, the Facility Director identified the need for a comprehensive approach to improving ISPs and set up the ISP Workgroup. After reviewing the Monitoring Team's report, a group including the Settlement Agreement Coordinator, QDDP Coordinator, the Assistant Director of Programs, and the State Office Program Compliance Coordinator identified a number of areas that crossed disciplines and required attention. At a meeting on 1/17/13, areas of focus were identified including: 1) assessments (i.e., quality, identifying needed assessments, recommendations related to transition to the community, and timely completion); 2) the ISP meeting (i.e., identifying necessary team members, starting on time, preparation prior to the meeting, draft plans in hand for discussion and finalization, and attendance); 3) documentation following the meeting (i.e., timeliness, complete information, development of good examples of key documents); and 4) plan development and implementation (i.e., meeting implementation timelines, tracking implementation, clinical indicators, and objective development). Action plans were developed for each of these areas, and at the time of the review, they were in various stages of implementation. Although this initiative did not emanate primarily from data the Facility collected, it was positive the Facility had used available feedback to initiate changes. Areas in which improvements should continue to be made in order to achieve substantial compliance, included: ▪ At the time of the review, the Facility was transitioning to the use of the new monitoring form. It was entitled: Annual ISP Meeting Preparation Checklist, dated 3/7/13. However, this was in the beginning stages of implementation. Draft instructions were submitted, but these were extremely general and did not identify standards for assessing compliance. As noted with regard to the Self-Assessment, some significant concerns remained with regard to the indicators. Some of them could be answered in the affirmative without the auditor assessing	

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		the quality as opposed to just the mere presence of an item. This, amongst other factors, likely contributed to the much higher ratings the Facility calculated for specific sections of the Settlement Agreement in contrast with the Monitoring Team. The following are just a couple of examples from the Annual ISP Meeting Preparation Checklist, which was identified as the tool that would be used moving forward: 1) Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate; or 2) Was the ISP meeting Guide completed, including the personal preferences and strengths? Either of these could be rated as compliant without the quality being assessed. ▪ Based on data submitted with regard to auditing that occurred in May 2013, inter-rater reliability was estimated to be between 90 and 95%. However, based on the Facility's findings that month that showed 100% compliance with all but a few indicators in comparison with the Monitoring Team's findings related to some of the most recent plans, it appeared that the Facility's monitoring might be reliable, but it was not valid. This is particularly problematic, because the Facility's Self-Assessment will not be accurate, and, as a result, the Facility will not be able to appropriately identify and address areas of concern. ▪ The Facility's data identified areas in need of improvement. Some improvement was seen in the analysis of this data, and identification of steps that either had been taken or were planned. However, based on review of the Facility's Self-Assessment this was not consistent across the subsections for Section F, and, at times, the references to potential reasons for noncompliance and/or proposed corrective action were brief and uninformative. The QA Department documentation provided showed limited identification of issues. However, as noted above, the Facility Director had identified the need to focus on ISPs and their development, and the ISP Workgroup had put a number of plans in place that should address a number of issues. Although progress clearly had been made since the last review, the Facility remained out of compliance with this provision. It was positive that data was being collected, and some analysis was occurring. However, more work was needed to ensure the comprehensiveness and validity of the data, and to fully utilize the data for quality assurance purposes. Particularly, as some of the Facility's action plans, including those the ISP Workgroup developed, are implemented, auditing will be instrumental in assisting the Facility to determine if the corrective actions are having the desired impact.	

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 morning medical meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: from June 10, 2013 through June 14, 2013; o For hospitalizations during the prior six months, follow-up ISPAs; o For one individual from each residential home, all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPNs) commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing), and any ISP addendum related to the consultant report; o Attendance data for ISPs November 2012 through June 2013; and o Evidence of examples of recommendations ISPAs or open record reviews followed through to closure until evidence that recommendation was completed. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shults, RN, BSN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used data and information generated from the provider morning meeting, such as meeting attendance by department; tracking/monitoring of open record reviews to closure; tracking or post hospital Individual Support Plan Addendums to closure; and tracking of other closure concerns requested at the provider morning meeting such as ISPAs for change of health status, refused appointments, consultations needing Interdisciplinary Team (IDT) response, audits of consultation review, and Primary Care Practitioner (PCP) IPNs. ▪ Some of these activities involved methodologies, such as record reviews, tracking logs, and review of documents as evidence of closure, etc. ▪ 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). These sample size(s) were adequate to consider them representative samples. ▪ The following staff/positions were responsible for completing the reviews: Medical Program Compliance Nurse, Medical Director, Clinic RN Manager, and Clinic Licensed Vocational Nurse (LVN). ▪ Inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The quality of the data maintained in the databases for Section G was noted to be complete and accurate.

	▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment provided logs for closure of post hospital ISPAs, closure concerns identified by the provider morning meeting, and open record review closures. In doing so, the Facility: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o All data for this section was collected by the Medical Department. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section G: G.1, and G.2. This was not consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The provider morning meeting with the referral process to the interdisciplinary team (IDT) as needed, along with tracking of several clinical areas, represented a well-integrated approach to clinical care. It also set the expectation of prompt response to concerns and resolution of problems. The provider morning meeting represented nearly all clinical disciplines on a routine basis. Departmental representation was tracked, as were follow-up concerns to post hospital Individual Support Plan Addenda (ISPAs), open record review recommendations, and other clinical concerns needing closure. The attendance by the Qualified Developmental Disabilities Professional (QDDP) Educator provided a mechanism for communication to the IDTs needing to respond to concerns and/or needing to meet to develop an ISPA. The provider morning meeting participants also reviewed the ISPAs for quality of content to ensure the concern was addressed. When not, it was referred back to the IDT, often with additional suggestions and guidance. The consultant reports were reviewed and IPNs were written in response. This occurred in parallel with the provider morning meeting, referring consultation reports to the IDT for an ISPA if appropriate. It was unclear how the information from the open chart reviews was processed by the IDT, and whether this was included when applicable in a subsequent ISPA. Although copies of the post hospital open record reviews were not requested, a review of the ISPA demonstrated little to no reference to any findings from the open record reviews. If there were findings, then referencing the findings and including this information in the deliberations and recommendations of the post hospital ISPA or follow up ISPA would demonstrate incorporation of this information into the team process. Other areas requiring attention included PCPs' attendance at ISPA meetings at which hospitalizations were being discussed, and timely response to PNMT recommendations requiring PCP orders. The Monitoring Team found the Facility was in compliance with Section G.2. The Monitoring Team found the Facility was in noncompliance with Section G.1.

#	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	A sample of provider morning meeting minutes was submitted. The dates of these meeting minutes were from June 10, 2013 through June 14, 2013. According to the Medical Department, the following departments were required to be	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>represented at the provider morning meetings: PCPs, other Medical Department staff, dental staff, pharmacy, residential department/QDDP Educator, psychology, nursing [Infection Control RN, Hospital Liaison Nurse, Registered Nurse Case Manger (RNCM) supervisor, Unit RN, and the Compliance RN for Health Services], habilitation/Physical and Nutritional Management Team (PNMT), and the Quality Assurance (QA) Department. Specific staff and departments were tracked for percentage attendance.

An attendance roster was provided for 5 of 5 (100%) days. The following information was obtained from the data submitted for this time period:
Medical Director: Two of five (40%);
PCPs (3): 15 of 15 (100%);
Medical Compliance Nurse: Five of five (100%);
Medical Department clinic representative (1): Five of five (100%);
Psychiatry (2): Eight of 10 (80%);
Dental Department representative (1): Four of five (80%);
Nursing administration representative (1): One of five (20%);
Unit RN Manager/RNCM Supervisor representative (1): Four of five (80%);
PNMT representative: Five of five (100%);
Pharmacy (2): 10 of 10 (100%);
Psychology (1): Five of five (100%);
QDDP representative (1): Five of five (100%);
Unit Director: not recorded;
Direct Support Professional (DSP) representative: not recorded;
Hospital Liaison Nurse (1): Four of five (80%);
QA representative (1): Five of five (100%);
Lab (1): Two of five (40%);
Infection Control Nurse representative (1): Two of five (40%); and
Dietary: not recorded.
Separately, data was submitted reviewing the attendance rate per month from September 2012 through May 2013. The following represented the attendance rates for the required departments over the prior three quarters:

<table><tr><th>Department/ Representation</th><th>September to November 2012</th><th>December 2012 to February 2013</th><th>March to May 2013</th></tr><tr><td>PCPs</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Medical Department staff</td><td>100%</td><td>97%</td><td>98%</td></tr><tr><td>Dental</td><td>62%</td><td>77%</td><td>81%</td></tr><tr><td>Pharmacy</td><td>100%</td><td>98%</td><td>97%</td></tr></table></td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Residential/QDDP Educator	100%	80%	92%
Psychology	97%	93%	95%
Nursing (not further defined)	100%	100%	95%
Habilitation/PNMT	91%	96%	98%
QA	92%	95%	97%

Supporting data was provided for each day of each month, along with bar graphs to visualize attendance per department representation, and overall attendance each day of the month.

The following information summarizes the contents of the five submitted morning medical meeting minutes:

- Five of five (100%) minutes included discussion of the Campus Coordinator Log.
- Five of five (100%) minutes included discussion of the on-call provider report.
- Four of five minutes included a report by the Hospital Liaison Nurse or delegate.
- One of five minutes documented the appointment/assignment of a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit. Two assignments were documented for these five meeting minutes.
- One of five minutes included discussion of results of an open record review.
- One document included additional information provided through a Medical Director announcement. One Medical Director announcement was documented.
- Five of five meeting minutes included the status of closure concerns.
- There were two new concerns needing closure that were identified.
- Two concerns tracked for closure were completed during these five meetings.
- There was additional discussion for two closure concerns in these meeting minutes.
- Five meeting minutes reviewed ISPAs as part of the closure process at the provider morning meeting.
    - A total of nine ISPAs were reviewed.
    - The provider morning meeting participants approved seven of nine ISPAs, because they addressed the concern directed to the IDT.
    - Two of nine ISPAs were returned to the IDT for further review to address the concern.
- Five meeting minutes reviewed consult reports, as well as whether scheduled consults were not completed.
    - A total of 11 consults were reported or updates provided as to status of the consultation.

#	Provision	Assessment of Status	Compliance
		▪ No meeting minutes recorded a PNMT report. ▪ One set of meeting minutes recorded an update concerning a chemical restraint. ▪ One set of meeting minutes recorded a skin integrity report. ▪ No meeting minutes recorded a report of any individuals with significant weight gain or loss. ▪ No meeting minutes included a discussion/in-service of systemic medical concerns, policies or procedures, quarterly analyses of data, etc. The Facility submitted concerns identified as needing closure at the morning provider meetings for the 30 to 60 days prior to the Monitoring Team's visit. Requested was any documentation providing evidence of closure. The time period of submitted documentation was from 4/2/13 to 6/6/13. ▪ During this time, there were 12 open record reviews requested at the provider morning meetings. Eight open record reviews were presented to the provider morning meeting and closed. ▪ Thirty-three ISPAs were requested by the provider morning meeting. Of these, 29 had closure and four were returned to the IDT for further review. ▪ Other areas were identified that needed closure. Twenty-two concerns were identified and assigned to staff for closure. Twenty-one of these concerns were closed. The Medical Department provided examples of various types of closure concerns from September 2012 through May 2013. On November 21, 2012, the 3rd quarter Emergency Room (ER) and hospital data was reviewed at the provider morning meeting. A trend was identified of dehydration and fecal impaction, which resulted in a corrective action plan. Direct support professionals were trained on documentation of fluid intake and bowel management information on the Treatment/Order Record (TOR), which was implemented in January 2013. This training occurred in three residences and was completed on 1/16/13. For any concern to have closure, the Medical Compliance Nurse required all documentation as evidence. Examples of required documentation included: copy of the training material, rosters of any training completed, copy of ISPAs, signature sheet from ISPAs, etc. Submitted was a document entitled "ISP Attendance and Assessment DATA November 2012 – June 2013: Attendance Data," which provided information concerning departmental representation at ISP meetings. Information was provided in this document for the following clinical departments concerning attendance representation by department:	

#	Provision	Assessment of Status	Compliance

Department	April 2013	May 2013	June 2013
Psychology/Board Certified Behavior Analyst (BCBA)	94%	100%	93%
Registered Nurse (RN)	95%	94%	94%
Occupational Therapist (OT)	100%	100%	100%
Physical Therapist (PT)	100%	100%	100%
Speech and Language Pathologist (SLP)	100%	100%	86%
Dietary	100%	100%	100%
PCP	91%	81%	94%
Psychiatry	100%	100%	100%
Dental	NA	NA	NA
Pharmacy	NA	NA	NA

The lack of tracking and/or presence of Dental and Pharmacy attendance at ISPs was noted. The Dental Department had a contribution to make to the IDT process, including risk rating for Dental Care and development of related action plans, but also to review any refused or missed appointments and the potential to discuss and update of desensitization plans. The minutes of the LBSSLC Dental Conference Call on 10/23/12 indicated that dental attendance was "requested" when the individual was rated as high risk for dental issues and/or other related concerns such as aspiration/respiratory compromise, the individual was receiving dental desensitization training, and/or the dental procedures required sedation prior to the visit or restraints during the procedure. At a minimum the expectation was the dentist was to attend for the integrated risk discussion and action plan. Pharmacy also had a role to play in developing a risk rating for polypharmacy and development of related action plans, as well as review of Quarterly Drug Regime Review (QDRR) data, especially if it involved recognition of side effects, drug-drug or drug-food interactions, or new medication in the prior year.

The Facility submitted ISPAs generated for hospitalizations that occurred during the six months prior to the Monitoring Team's visit. Of these submitted, the most recent ISPAs from February through May 2013 were reviewed. This included ISPAs for 17 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.

For these 17, none of the individuals were hospitalized for concerns that did not apply to these measures and therefore, none were excluded (i.e., planned surgery, etc.). Several individuals had more than one hospitalization, and measurements did not separate out

#	Provision	Assessment of Status	Compliance
		the various admissions per individual. All documentation related to the hospitalizations was used to monitor the quality of the team approach to resolving health care issues and 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 include the following: ▪ Reference to a record review/open record review was documented in zero of 17 (0%) individuals. o One of the goals of the record review was to determine if there were any early warning signs or symptoms of the acute illness in the individual, which could then be shared with staff. Earlier recognition of disease would potentially reduce morbidity and prompt resolution of the illness. During reviews, nursing and direct support professionals' notations also would be reviewed to determine quality. Timeliness of communication with the PCP also could be reviewed at the time of the record review. If completed, any results would be expected to be incorporated into the ISPA process. However, not all open record reviews would be expected to have findings, and one open record review identified the need for nursing in-service training on enteral feeding pumps as a systemic quality improvement initiative rather than a specific recommendation to be included in the ISPA. Although the initial post-hospital ISPA would often occur before the completion of the open record review, a follow-up ISPA would be expected to include this information. To synchronize the timing of completion of the open record review, it is recommended the open record review be assigned in the initial stage of hospitalization with results available by time of discharge. Although this is not always applicable (e.g., short hospital stay, or when a specific diagnosis is needed to guide the review and the Hospital Liaison Nurse report does not identify a clear diagnosis because the evaluation was not yet completed), the reviewer should strive to ensure the results of the open record review are available to the IDT at the time of the post-hospital ISPA or in a follow-up ISPA a few days later. It would provide added documentation of IDT review to include a comment that the findings of the open record review were discussed and addressed, or that there were no additional recommendations from the open record review process. ▪ The IDT identified new triggers or early signs/symptoms in five of 17 individuals. ▪ The IDT identified the need for increased monitoring in one or more aspects of care in 10 of 17 individuals.	

#	Provision	Assessment of Status	Compliance
		▪ The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 11 of 17 individuals. ▪ The time from the discharge date of the hospitalization to the creation of the initial ISPA was within five days in 15 of 17 (88%) ISPAs submitted. ▪ There was documentation the PCP attended the meeting in eight of 17 (47%) ISPAs. Given that these were ISPAs related to hospitalizations, it was important that PCPs attend. Additionally, it was noted that when there were results from the record review, this information was not reflected in the post-hospital ISPA, because it would often occur subsequent to the ISPA. However, it was noted that record review findings were tracked through the provider morning meeting and recommendations followed to closure. As an example, one individual was found to have dehydration, and it was determined the nurse needed training on new feeding pumps. Training was tracked to completion. As mentioned earlier, a subsequent ISPA should incorporate the findings of the open record review in its deliberations and recommendations. One opportunity/challenge is to assign the open chart review early in the hospitalization in order for results to be available at the time of discharge and available for review by the IDT and incorporation into the ISPA. Reference to the findings of the open record review in the ISPA would provide evidence the results had been incorporated into the interdisciplinary care of the individual. The results would assist the IDT in developing a quality ISPA. Additionally, open record reviews with recommendations for systemic improvements would be followed through to closure at the provider morning meeting. The provider morning meeting also tracked change of health status, and requested ISPA addendums based on needs identified that required IDT collaboration. This is further discussed with regard to Section H. The Facility was asked to submit the 10 most recent PNMT recommendations for which physician's orders were written based on PNMT recommendations. Two of 10 recommendations were submitted. One recommendation occurred on 3/12/13, with orders written on 4/15/13. One recommendation occurred on 2/26/13, with orders written 4/4/13. No further information was provided with the submitted documents. However, the Self-Assessment for Section G indicated that there were 14 PNMT recommendations, which required a physician order during the time period November 2012 through May 2013. Of these 14 recommendations, five physician orders were written. This was an area that needed attention. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as areas of focus/priority for the next six months:	

#	Provision	Assessment of Status	Compliance
		▪ To improve the ISPA process, it is recommended that PCPs attend post hospital ISPAs. This likely would improve the acceptance rate of ISPAs by the provider morning meeting. ▪ In addition to completing ISPAs following hospitalization, IDTs should meet and develop ISPAs for follow-up of refused appointments, when consultant recommendations require IDT review to ensure implementation of the recommendations, and to incorporate information from the consultant reports into the ISP, IRRF, etc. Although progress had been made, the Facility remained in noncompliance with this provision.	
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 was asked to submit consultant reports for one individual from each residence, as well as any IPNs commenting on the consultant reports. Consultations for 15 individuals were submitted, with a range of two to 12 consultations per individual. A total of 85 consultant reports were submitted. Review of these documents revealed the following: ▪ Of the 85 reviewed, 84 required review by the PCP (one was a refused appointment). Eighty-one of 84 (96%) included the PCP initials, indicating review by the PCP. ▪ Of the 84 reviewed, 81 (96%) 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 and reviewed. o Of the 84 reviewed, 81 (96%) consults included documentation of agreement or not with the consultant recommendations. o Of these 84, 79 (94%) included PCP IPN entries that documented agreement or not. o Looking at both combined, of the 84, 84 (100%) had evidence of review and agreement either through a notation on the consult report and/or a PCP IPN entry. ▪ Of these, one ISPA was submitted for the one refusal of the consult appointment. ▪ Zero ISPAs were submitted which documented the discussion of the contents of the consultant reports, and the PCP's recommendation. However, it was noted that consultant reports were reviewed at the provider morning meeting. When a recommendation required IDT action, an ISPA was requested at that time. This ensured the IDT became aware of the recommendation, created an ISPA, and was followed by a review at the provider morning meeting to ensure it met the needs of the individual and addressed the recommendation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Separately, it was noted that the Medical Department conducted an internal review of consultation reviews and follow-ups. From 11/1/12 through 5/31/13, 359 consultations were identified. Of these, 28 were reviewed (a sample size of 8%). This was a random sample. The measurement indicators included whether there was a PCP IPN documenting review of the consult with agreement or disagreement. Compliance for these 28 consultations was 100%. It was not identified if this was a one time internal audit, or an example of a periodic audit. However, the Monitoring Team would suggest this was a valuable process, and the internal audit of the consultation process should be ongoing. Based on these findings, the Facility was found to be in substantial compliance with this provision.	

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 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 Assessment; Annual Medical Summary, including the Active Problem List, Inactive Problem List, and Psychiatric Problem List; Hospital Admission section; Health Risk Assessment Rating – tool and team meeting sheet (only most recent); Psychiatry section, including the most recent Comprehensive Psychiatric Assessment; MOSES; DISCUS; Side Effects Screening section; Quarterly Drug Regimen Reviews (QDRR); 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 Monitoring Team's pre-review document request and considered to be psychiatrically stable: Individual #7, Individual #146, Individual #183, Individual #50, Individual #127, Individual #6, Individual #103, Individual #310, Individual #254, and Individual #82; o The same set of records was requested during the onsite review for the following individuals: Individual #30, Individual #320, Individual #233, Individual #68, Individual #213, Individual #126, Individual #79, Individual #8, and Individual #114; o For four individuals from each PCP's caseload, four diagnoses identified from the active problem list of the most recent annual medical assessments, with criteria for justification from the active record, including copies of supporting documentation; and o ISP Assessment tracking November 2012 through June 2013. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; o Leah Shults, RN, BSN, Medical Program Compliance Nurse; and o Dawn Ripley, QA Director.
	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 the Facility conducted for its self-assessment included: monitoring of ISP assessment completion, monitoring of completion of annual medical and annual dental assessments, tracking of change of status until closure, and the Medical Department quality improvement monitoring tools (10 tools).

	○ These monitoring/audit tools included a number of helpful 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 indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as record reviews, review of provider morning meeting minutes, etc. ○ 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). These sample sizes were adequate to consider them representative samples. ○ The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse, Medical Director, Clinic RN Manager, and Clinic LVN. ○ Based on their credentials, the staff responsible for conducting the audits/monitoring appeared 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 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. ○ The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility presented some data in a meaningful/useful way, but some problems were noted. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section H: H.2. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example the need for additional clinical indicators.
	Summary of Monitor's Assessment: Several advances were noted with this section. Records indicated appropriate criteria to justify diagnoses. Several Medical Department quality improvement (QI) tools were added to the existing number, in order to track various aspects of quality care. The provider morning meetings monitored significant change in health status, and several other associated measureable steps were created or continued with follow-up to closure. The QA Department followed medical peer review audit action plans to closure. Periodic assessments (quarterly medical reviews and QDRRs) were completed in a timely manner. Challenges were also noted. Annual medical assessments and annual dental assessments were timely less than 90 percent of the time. Although most departments were able to submit completed assessments for ISP preparation in a timely manner, the nursing department lagged in this area. Although the Medical Department created additional QI monitoring tools, development was needed of audit tools to review

	active records in determining whether common elements of clinical care were provided for various diagnoses, using the clinical guidelines or other resources. Dental annual summaries were based, at times, on data from annual exams completed months prior, rather than ensuring the summaries reflected updated information. For some individuals, there was no record of dental x-rays having been completed, which was problematic when reviewing this section for common elements of clinical care. A number of medical specialty appointments were missed. Evidence needed to be provided that follow-up appointments occurred in a timely manner to ensure common elements of clinical care were in place. The Monitoring Team found the Facility was in compliance with Section H.2, but not in compliance with Sections H.1, H.3, H.4, H.5, H.6, and H.7.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>H1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.</td><td>Several routine and periodic assessments were reviewed for timeliness for several clinical departments. These included the following:
In the prior 12 months, 144 of 205 (70%) medical annual assessments were completed in a timely manner.
For 23 of the most recent medical annual assessments, completion within 365 days of the prior assessment occurred in 20 of 23 (87%).
A review of six active records indicated that a medical annual assessment had been completed in the last 365 days in six of six (100%).
In the past six months, 86 of 99 (87%) dental annual evaluations were completed in a timely manner.
During the past two quarters, 841 of 852 (99%) QDRRs were completed in a timely manner.
<u>Assessments submitted for ISPs</u>
A document was submitted entitled "ISP Attendance and Assessment DATA November 2012 - June 2013: Assessment Data." This information provided timeliness of submission of annual assessments by departments. Information was provided in this document for the following clinical departments concerning timeliness of document submission 10 days prior to the ISP:

<table><tr><th>Department</th><th>April 2013</th><th>May 2013</th><th>June 2013</th></tr><tr><td>Psychological Assessment</td><td>86%</td><td>83%</td><td>94%</td></tr><tr><td>Psychiatry Assessment</td><td>50%</td><td>100%</td><td>100%</td></tr><tr><td>Occupational Therapy</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Physical Therapy</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Speech</td><td>100%</td><td>90%</td><td>91%</td></tr><tr><td>Audiology</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Nutrition Services Evaluation</td><td>100%</td><td>100%</td><td>94%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Medical Assessment	95%	89%	100%
Nursing Assessment	45%	17%	38%
Dental Assessment	82%	78%	81%

Tracking of changes in health status

For changes in health status, the provider morning meeting documented all significant changes in health that occurred, and reviewed all cases of significant health status change. Documents reviewed included the 24-hour Campus Log, the Hospital Liaison Nurse reports for those hospitalized, consult recommendations, and on-call physician information. Information discussed regarding change of health status occurred at the next provider morning meeting.

Based on this information and discussion, the Medical Director and/or Medical Compliance Nurse would request that the IDT meet to create an ISPA, or assign a concern for closure. Both routes had had meticulous follow through to presentation back to the provider morning meeting, and subsequent closure or routing back to the IDT for further review. For those ISPAs returned for the IDT's further review, the ISPA tracking log frequently included specific areas needing clarification or aspects of guidance to assist the team in developing an acceptable ISPA. When members made recommendations at the provider morning meeting, these were tracked for progress and completion. The goal was to ensure all health and safety needs of the individual were completed. Written documentation was required before closure was accomplished. The QDDP Educator attended the provider morning meetings and was able to quickly take the request to the appropriate QDDP to begin the ISPA process. Once created, the QDDP Educator presented the ISPA to the provider morning meeting members.

Copies of the ISPA tracking logs were submitted. The log content included the individual's name, reason for the referral, the date of request, date of second request if necessary, the date received, the date presented at the provider morning meeting, whether the ISPA was accepted, entry notes of comments, additional recommendations, etc., a copy of the attendance roster for the ISP, and the QDDP responsible for timely completion of the ISPA. The log provided a detailed tracking system to ensure timeliness of response. The following lists the number of ISPAs per month requested and reviewed by the provider morning meeting to ensure the ISPA addressed the concerns:

Month	ISPAs requested	ISPAs Received/Reviewed and Accepted
November 2012	19	17
December 2012	16	16
January 2013	17	17

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February 2013	8	8
March 2013	7	7
April 2013	12	12
May 2013	20	20

As discussed with regard to Section I.2, based on a review of the records of individuals with a number of risk areas, medical and other assessments were not consistently and thoroughly completed. At times, these individuals had had a number of changes of status, including unplanned hospitalizations. However, teams were not consistently identifying the need for further assessment.

The Facility remained out of compliance with this provision. Although some annual and quarterly assessments were timely, others were not. Notable progress had been made with regard to the Facility's identification and response to changes in status. However, ensuring full sets of assessments were completed to address significant changes in status and prevent, to the extent possible, re-hospitalization was an area that continued to need focus.

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H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	A sample of medical diagnoses listed in individuals' active problem lists was submitted. The sample was derived from four active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. The PCPs were asked to provide the criteria or evidence used to determine whether 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 20 individuals, 80 diagnoses were listed, along with submission of criteria to justify the diagnosis. Review of the 80 diagnoses, along with review of the submitted evidence for each diagnosis, determined that 77 of 80 (96%) diagnoses had adequate supportive documentation to verify the diagnosis listed. The Medical Department indicated there were no new in-service trainings on ICD and DSM diagnostic criteria during the prior six months. Although not necessary for compliance, it would be helpful training for PCPs to have. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed for Section J, there was adequate clinical justification for the diagnosis of record for 19 of the 19 individuals (100%). With the completion of Comprehensive Psychiatric Evaluations, annual Psychiatric Treatment Plans, and ongoing quarterly updates for everyone prescribed psychotropic medication, the Facility had solidified its diagnostic practices related to psychiatric disorders.	Substantial Compliance

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		The Facility remained in substantial 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 appropriate based upon assessments and diagnoses.	The submitted medical diagnoses and supporting criteria for Section H.2 demonstrated that 96 percent of diagnoses were appropriate based on these criteria. Criteria included assessments by PCPs, as well as specialty consultation and numerous diagnostic tests. Based on this sound clinical foundation, treatments and interventions were then ordered by the PCPs. The provider morning meeting minutes documented that the response to clinical concerns were timely once they were brought to the attention of the PCP. The provider morning meeting process then tracked significant health status change to completion. At the provider morning meeting, discussion among all departments provided an inter-departmental approach to appropriate clinical care. Treatments were based on diagnostic results, consultant recommendations, and physical exam, as discussed by the on-call or attending physician. This process was well documented through the provider morning meeting process. Additionally, there were two audit processes that measured whether some treatments and interventions were timely and clinically appropriate. The external and internal medical peer review, general medical audit, and medical management audits had several clinical indicators that measured treatment and interventions. For the external medical peer review of February 2013, the State's data showed that compliance in essential areas ranged from 82 to 90 percent. For non-essential areas, compliance ranged from 80 to 100 percent. Compliance of essential components required 100 percent compliance according to original State Office guidelines. Compliance in non-essential areas was considered to be 90 percent. The internal medical peer review of November 2012 indicated that PCP compliance in essential areas ranged from 94 to 100 percent. For the medical management, compliance ranged from 40 to 100 percent. For the internal medical peer review of February 2013, compliance in essential areas ranged from 83 to 100 percent. For non-essential areas, compliance ranged from 88 to 100 percent. For the May 2013 internal medical peer review, compliance of essential areas ranged from 93 to 100 percent, and for nonessential areas, from 89 to 100 percent. Compliance for medical management ranged from 89 to 100 percent. Further details are provided with regard to Sections L.2 and L.3. The medical management scores in the internal medical peer review audits appeared to show improvement. The Medical Department also created several QI monitoring tools for specific diagnoses and clinical situations. Some of the clinical indicators addressed treatment and interventions. Examples included: ▪ Aspiration pneumonia o "If the individual has GERD [gastroesophageal reflux disease] or	Noncompliance

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		gastritis is he/she taking a PPI [proton-pump inhibitor] or HistamineH2 receptor antagonist?" o "Did the provider order a HOBE [Head of Bed Evaluation]?" and o "Does the individual receive suction tooth-brushing or been referred to dental?" ▪ Seizures o "Anti-epileptic drug levels are drawn every 6 months and when clinically indicated;" and o "Ativan/Diastat are used appropriately for prn seizure control." ▪ Hypertension o "Does the individual have a 'Heart Healthy Diet' ordered?" ▪ Constipation o "Fiber supplement ordered if needed?" and o "Medical management ordered." ▪ Metabolic syndrome o "Low dose aspirin is prescribed if there are no contraindications;" o "A low fat diet is ordered;" and o "Adequate fiber is prescribed either through diet or supplement." ▪ Diabetes mellitus o "Hemoglobin A1C is performed at least twice a year;" o "Podiatry exam is performed annually;" o "Ophthalmology exam is performed annually;" and o "An appropriate diet has been ordered." ▪ Down's syndrome o "Annual TSH [thyroid stimulating hormone] and T4 is drawn;" o "Ophthalmology exam is performed every 2-3 years;" and o "Auditory testing is performed every 1-2 years." ▪ Prader-Willi o "Has the individual had a DEXA scan?" and o "Does the individual receive adequate calcium, either through diet or supplement?" The above examples were a few of the many indicators from these monitoring tools that measured the quality of treatment and intervention. Each of the monitoring tools had several questions that could have been given as examples. For results of these internal monitoring tools, more information is discussed with regard to Section L.3. As part of the provider morning meeting, individuals hospitalized for acute illness had an "open medical chart review"/record review completed. This was assigned at the provider morning meeting to a member of a clinical department. Focus was to review the days preceding the acute illness to determine if the medical care was timely, if the	

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		medical care was appropriate, if there were subtle signs and symptoms that preceded the acute illness, and what additional preventive steps should be considered to prevent a recurrence of the acute illness. This was then reported back to the provider morning meeting, and recommendations that were a result of the open record review were tracked to closure. The following listed the number of record reviews assigned with progress toward closure:	

Month	Number of Record Reviews	Number Reviewed at Provider Morning Meeting
January 2013	6	6
February 2013	4	4
March 2013	5	5
April 2013	7	7
May 2013	8	5

The recommendations from the record reviews varied from medical concerns to nursing concerns. When a recommendation indicated a systems level concern, an action plan was generated. When a training need was identified, the recommendation was tracked and closed when a training roster was received.

However, as noted with regard to Section G.1, based on a review of a sample of 17 individuals' ISPAs, the results of the open record reviews were not referenced. As noted above, one of the goals of the record review was to determine if there were any early warning signs or symptoms of the acute illness in the individual, which could then be shared with staff. Earlier recognition of disease would potentially reduce morbidity and prompt resolution of the illness. The open record review is an additional opportunity to review whether the PCP should have been contacted sooner, and whether documentation by other disciplines in the records was timely and thorough. It was concerning that these reviews were not regularly being used to inform treatment.

The Medical Department recently had taken steps to improve the timeliness of completion of open record reviews, which will provide important information to the provider morning meeting and the IDT in a briefer time span. It is realized that the open record review might not be accomplished by the time of the IDT meeting and initial post-hospital ISPA. However, any relevant follow-up information from the open record review should be incorporated in a follow-up ISPA as evidence any findings were incorporated into the interdisciplinary approach and to ensure all IDT members are aware of this information. Further, assignment of the record review early in the hospitalization might allow results to be available when the post-hospital ISPA is developed.

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		Although these were positive steps, the Facility had not fully implemented mechanisms to determine if the full range of treatments and interventions were timely and clinically appropriate. For example, as discussed with regard to Section M, Section I, and Section O, concerns continued to be noted with regard to the identification and provision of healthcare supports. The Medical Department was beginning to use protocols to measure quality of treatments, but this was in the initial phases. It will be important to use information gained from these processes to address any issues identified (e.g., corrective actions taken by the Medical Department based on the findings of these internal QA audits). The Facility remained out of compliance with this provision.	
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.	For the monitoring tools listed with regard to Section H.3, the quality indicators relied on measurable responses or results [i.e., a specific diet was ordered (Y/N), a specific medication was ordered (Y/N), or physiologic parameters were stated (blood pressure) (Y/N)]. It is recommended that these quality indicators be expanded to include lab values as additional goals based on information provided from the clinical guidelines/pathways and national standards. Determining the normal range or threshold value (e.g., for HgbA1C, Vitamin D level, etc.), would provide evidence of "efficacy of treatment" or whether additional treatment or changes in medication were needed. Referencing the source of information in a footnote or in a policy that provided guidance in creating clinical indicators would ensure clinical justification of those goals/levels. Additionally, providing a system for constantly updating the clinical indicators as advances are made in medicine should be an ongoing aspect of QI monitoring. In addition, as discussed in previous reports, the individualized integrated health care plans (discussed with regard to Section I) should identify measurable objectives in achieving a clinical outcome. These measurable objectives could be tracked, and the clinical outcome or clinical indicator of health also could be followed to determine whether treatment is adequate, needs to be changed, or needs to be augmented in some way. This could occur at the individual level, but data also could be collected and analyzed on a more systemic level. The Facility was in the initial stages of identifying and implementing clinical indicators to assess the efficacy of treatments. LBSSLC remained out of compliance with this provision.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established	The Facility used several systems to monitor the health status of individuals. ▪ The provider morning meeting met each workday. Included, as a part of the agenda, was the report from the on-call physician of concerns from the night before or the weekend before the meeting. This included a review of any acute	Noncompliance

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	and maintained to effectively monitor the health status of individuals.	care concerns for which a physician would need notification or if a physician order or clinical guidance was required. A 24-hour log of clinical concerns was reviewed. Hospitalizations were reviewed. The provider morning meeting monitored the acute care changes of all individuals residing at LBSSLC, whether they were at LBSSLC or in a hospital setting. If further clinical information was needed, the Medical Director assigned this to a meeting participant and information was brought back to the committee for review and closure. For those returning from a hospital, an ISPA was developed and reviewed at the provider morning meeting to ensure it met the health and safety needs of the individual. ▪ Consultations were discussed at the provider morning meeting, which reviewed updated health status information concerning individuals. Additionally, diagnostic testing (e.g., lab and radiologic testing) was discussed, including those scheduled for appointments, those that completed an appointment, and those unable to complete the appointment. Selected diagnostic reports were reviewed at the provider morning meeting. This was an effective and sustainable system, which monitored acute care and ongoing health status of the individuals on a daily basis. ▪ Additionally, health status was measured at periodic intervals. For instance, 208 of 208 (100%) active medical records included current quarterly medical notes. Ninety-nine percent of QDRRs were completed on schedule. Preventive testing was monitored through databases specific to the test, such as mammograms and colonoscopies. However, there were areas that remained challenging. The dental annual summaries at times did not represent current information, and were, at times, extracted from dental annual exams that had occurred months to over a year in the past. Some individuals had no record of ever having had a dental radiograph. The Dental Department did not appear to have a system in place to track improvement of periodontal condition to determine if treatment or tooth brushing skills were adequate. For some specialties, the number and percentage of missed appointments was problematic. Rescheduling and delays in appointments and follow-up of care made monitoring of health challenging when reviewing clinical areas needing specialty input. As is discussed in more detail with regard to Section M.1, challenges remained in the Nursing Department and in the residential services in identifying health status change at an early stage, and providing appropriate monitoring once a concern was identified. As a result of these various deficiencies, the Facility remained out of compliance with this provision.	
H6	Commencing within six months of	As part of the external and internal medical peer review audit process, six diagnoses	Noncompliance

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	the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	were targeted for review. The QA Department tracked deficiencies in the responses to the clinical indicators until resolution through action plans. Similarly, the Medical Department had developed several clinical guidelines. Results provided guidance whether the treatments and interventions were adequate or needed modification. ISPAs with a medical focus were reviewed at the provider morning meeting, and if found to not address health and safety needs adequately, were returned to the IDT for further review, often with information as to why the ISPA needed further review. The chemical restraint form was a multidisciplinary form that evaluated the use of the chemical restraint to determine if it was justified, but also to determine if it was effective. This form evaluated both areas of clinical care: whether a change in treatment was needed concerning the Behavior Support Plan (BSP), and whether a change in interventions was needed (i.e., change in medication or change in dosage of medication or change in route of administration of medication). This form needed improved documentation by both pharmacy and psychiatry to make it meaningful to the IDTs. A monthly Facility Polypharmacy meeting was held to review the treatment of individuals with psychotropic polypharmacy, and to determine if changes in medication were needed. There were areas of challenge remaining. For example, it was not clear how the Dental Department tracked oral sedation serially to determine the most effective minimal dosage for an individual, which would allow for the individual's cooperation in the Dental Department. Individuals with significant weight gains or losses did not appear to be tracked to determine if interventions and treatments were appropriate or needed review and modification. The Skin Integrity Committee minutes did not appear to provide updated information for the decubiti of individuals, nor treatments that were attempted and treatments that were changed, based on healing or not of the decubiti. It was also noted that the Skin Integrity Committee only met twice since October 2012, and the focus for one meeting was educational and not related to treatment and progress in healing of decubiti. There did not appear to be a system to track a pressure ulcer, including all the treatments provided to resolution. The Facility remained out of compliance with this provision.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical	The Medical Department continued to expand standardization of clinical care of selected diagnoses relevant to those residing at LBSSLC. Additional clinical guidelines had been developed, trained, and implemented since the Monitoring Team's last visit. These included the following: ▪ "LbSSLC – Health Services: Clinical Guidelines - Tuberous Sclerosis" (dated	Noncompliance

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	services policies, procedures, and guidelines to implement the provisions of Section H.	10/25/12); ▪ "LbSSLC- Health Services: Clinical Guidelines – Metabolic Syndrome" (dated 10/25/12); ▪ "LbSSLC- Health Services: Clinical Guidelines – Prader-Willi" Syndrome (dated 10/25/12); and ▪ "LbSSLC – Health Services: Clinical Guidelines – Down Syndrome" (dated 10/25/12). 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, and attendance tracking for department representation at the provider morning meeting). To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: ▪ The Facility should create a policy/procedure that provides the blueprint for these system processes and interfaces, and captures the current activity at the Facility. Such a policy also should demonstrate where the "at risk" process is integrated into this process and at what level(s), both in defining risk rating, and in determining change of status. ▪ If not already clarified in a policy, guidance should be written regarding the specific areas the IDT is expected to review: post hospitalizations, ER visits, requests by the provider morning meeting, etc. It appears there are several functioning components in place, and the Facility should methodically review these processes to ensure policies are written which capture the details and the successful methodology of these systems. ▪ Additionally, there should be a policy focusing on monitoring and productivity of these interlocking systems, measuring each to ensure the process is efficient, responsive, functional, and of sufficient quality to meet the needs of the individual. This monitoring should be reviewed quarterly. The Facility remained out of compliance with this provision.	

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 LBSSLC's Self-Assessment; o LBSSLC's Section I Presentation Book; o LBSSLC At-Risk Individuals list; o The following documents: Integrated Risk Rating Forms (IRRFs), Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/Integrated Health Care Plans (IHCPs) for the following individuals: Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance; and o For the following individuals' active records, selected documents: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports for past one year, Do Not Resuscitate (DNR) forms if applicable, physician orders for past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form(s) for past one year, and integrated health care plan for: Individual #313, Individual #114, Individual #283, Individual #74, Individual #284, and Individual #139; and o ISP for Individual #242. ▪ **Interviews with**: o Robin Seale, Assistant Director of Programs; o Brandi Villarreal, RN, BSN, Chief Nurse Executive; o Lilly Burton, RN, Program Compliance Nurse; o Linda Thomas, OTR, Director Habilitation Therapy; and o Ric Savage, State Office Consultant. ▪ **Observations of**: o ISP Meeting for Individual #290, on 7/9/13; and o ISP Meeting for Individual #276, on 7/11/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. 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 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 reviewing and modifying its monitoring tool for Section I. In doing so, the Facility should include all of the requirements of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment: o Many of the indicators used by the Facility for this section, were not in alignment with the Monitoring Team's indicators. As the Facility continues to revise its monitoring tools, the Facility is encouraged to continue to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, the Facility should include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews, resulting in inaccurate data. In addition, further definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. o Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples were pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) will be necessary to determine the relevance of the data. 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 Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the supports provided and documentation maintained, auditors for this area should be deemed competent in the use of the tools and 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. At the time of the review, the Facility was in the process of developing a system for discipline-specific assessments to be reviewed by the appropriate discipline in order to determine the adequacy of the assessments. Although this was a positive step forward, in order to ensure the accuracy of the data, the Facility should develop specific criteria that outline the necessary criteria by which to evaluate quality in alignment with discipline-specific standards of practice. o Adequate inter-rater reliability should be established for the final 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 concerns with the overall data presentation, at the time of the review, the Facility did not yet have a consistent system for presenting data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present most findings based on specific, measurable indicators. For example, the

	Facility should be clear regarding what specific criteria had been used to determine compliance. In addition, data addressing items contained on the monitoring tools should be presented by month rather than by an overall compliance score that is not meaningful, and does not shows the areas of strength and weakness as well as the progress over time. 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, the Monitoring Team's findings addressed the quality aspect of the supports provided and documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how it will assess quality, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data.
	Summary of Monitor's Assessment: Since the last review, the Facility reported that of the 425 staff identified as needing training regarding the Individual Support Plan – At-Risk Individuals procedure, 365 staff (86%) had received the training. Also, additional training was provided to Facility staff by State Office discipline coordinators and/or consultants. The Competency Training Department reportedly would be tracking the implementation of the Integrated Health Care Plans, but had not yet developed a tool or received any training at the time of the review. In addition, in November 2012, the Facility had begun a mentoring group addressing the systems and documentation for the At-Risk system. The Facility was also in the process of reviewing hospitalization and emergency room data to ensure that Integrated Health Care Plans were in place for these individuals. Also, the Facility had initiated review of its high-risk data and any discrepancies found in the ratings were being reconciled to ensure the reliability of the data. Although from the ISP meetings the Monitoring Team observed during the onsite review, some positive changes were noted, there continued to be significant issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process. Regarding some of the Facility's auditing data for Section I, the Monitoring Team noted that the Facility was incorporating some of the indicators the Monitoring Team used for this area. However, most were not in alignment with the Monitoring Team's indicators and the quality of the assessment documentation was not being reviewed using specific criteria based on discipline-specific standards of practice. However, the Facility did indicate that this would be in process by the next review. In addition, at the time of the review, the Facility recently had decided to defer monitoring activities until all infrastructure systems were solidly in place. Due to the numerous changes to the At-Risk system, the documentation continued to include many deficiencies found by both the Facility and the Monitoring Team. Specifically, the quality of the IRRFs varied, and the Integrated Health Care Plans generally were of poor quality. The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding

	specific actions that were taken in response to pertinent events or health issues, and the lack of supporting documentation addressing actions and completion of actions continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the At-Risk system difficult.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	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. In response to this requirement, LBSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ Since the last review, the Facility reported that a review of the training data for the Individual Support Plan (ISP) – At-Risk Individuals procedure indicated that of the 425 staff identified as needing trained, 365 staff (86%) received the training. Also, additional training was provided to Facility staff by State Office discipline coordinators and/or consultants. The Facility reported that as procedures are revised, Facility staff would be trained by September 2013. In addition, training for this area would be tracked through Competency Training Department (CTD) resulting in a training and tracking report. ▪ The Facility's Self-Assessment indicated that there was a significant improvement in the data from September 2012 through May 2013 regarding if all individuals had a current risk ratings (within 12 months). However, problems also were noted in the Self-Assessment, such as the data for April 2013 was unavailable due to the implementation of the new risk database, and the data for May 2013 was in need of further investigation to determine if data had not been entered or if there was an issue with the new database. These problems suggested that the reported findings were inaccurate. Additional data contained in the Facility's Self-Assessment are discussed with regard to Sections I.2 and I.3 below. <u>Self-rating</u>: The Facility's Self-Assessment indicted that: "based on the findings of the self-assessment this provision is not in compliance as evidenced by a lack of consistent implementation of a regular risk screening, assessment and system which identifies individuals at risk. There are action plans in place to address these concerns." A review of the action plans for Section I.1 was conducted, and the following statuses of actions were identified: ▪ The first subsection addressed training to ensure IDT members completed competency-based training. The goal was for all IDTs and Department Heads to be trained. All steps were "in process" or "not started."	Noncompliance

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		▪ The second subsection involved implementing a monitoring system for the risk process, including database development. All steps were considered "in process" or "in progress" or had not been started. ▪ The third subsection involved creating a system to assist the completion of the IRRF. Two of the action plans in this subsection were considered completed. These action plans included tracking timely submission of the completed draft IRRF 10 working days prior to the ISP meeting, and implementing the tracking system. ▪ Under the fourth subsection "Implement Data/Risk Rating Review System," the step for identifying existing data to be used to determine inconsistencies in assigned risk ratings was documented as completed. The Facility provided evidence of the completion of some of these action steps with documentation of training of two IDTs from 10/29/12 to 11/1/12. Nine training rosters were submitted involving: conducting the pre-ISP for IDT A, conducting the pre-ISP for IDT B, the QDDP Mentors and IDT QDDP writing the pre-ISP and attachments, reviewing expectations of the assessments, and nursing documentation. Mentors were to complete monthly contact notes. The examples submitted were from 11/15/12 through 1/12/13. Additional actions taken since the last review addressing the At-Risk system included the following: ▪ In November 2012, a mentoring group addressing the systems and documentation for the At-Risk system was established; ▪ The Facility was in process of reviewing hospitalization and emergency room data to ensure that based on priority, Integrated Health Care Plans (IHCPs) were in place; ▪ The Facility's high-risk data was being reviewed and discrepancies in ratings were being reconciled; ▪ The QDDPs were given the nursing protocol cards in order to facilitate their use in developing the IHCPs; ▪ Problems were identified regarding the timeliness of some of the discipline ISP assessments that were causing delays in the filing of the ISPs into the Active Records; ▪ Interventions for individuals who experienced a change of status were now being reviewed at the morning provider meetings; ▪ The Facility was in the process of investigating why 50% of the individuals were deemed at high risk for dental issues; ▪ The Competency Training Department reportedly would be tracking the implementation of the IHCPs, but had not developed a tool or received any training at the time of the review; and ▪ The Facility recently had decided to defer monitoring activities until all	

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		infrastructure systems were in place. Although the Monitoring Team noted some improvement from the two ISPs observed on site, there continued to be significantly problematic issues as noted below. The numerous changes to the At-Risk system that had resulted in fragmented documentation made it difficult, if not impossible, in many cases to sequentially follow the assessment and care plan processes for a sample of 23 individuals discussed with regard to Sections I.2, and I.3, who the Facility determined to be at high risk regarding health and/or mental health issues. A review of the ISP and addendum documentation indicated that most individuals' teams were discussing 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, the Risk Action Plans/Integrated Health Care Plans, and the associated disciplines' assessments regarding what actions were taken and when in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans continued to negatively impact the supports that were planned for and provided to individuals, and made the Monitoring Team's review of the At-Risk system difficult. To assess the Facility's revised risk screening process, members of the Monitoring Team observed two individuals' ISPs meetings (i.e., Individual #290, and Individual #276) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at one (50%) of the observed ISPs. The Physical Therapist was not present for the ISP for Individual #290 who had a number of risk areas related to his physical and nutritional management needs such as osteoporosis, falls, and fractures, used pieces of adaptive equipment (wheelchair, gait belt), and had a walking program. ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for both (100%) of the ISPs. ▪ The individual was present at all (100%) of the ISPs meetings observed. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at two (100%) of the ISP meetings. ▪ The IDT consistently used supporting clinical data when determining risks levels for one (50%) of ISPs observed. The IDT for Individual #276 did not consistently use or have available supporting clinical data when determining risks. ▪ Overall, the risk levels the IDT designated were appropriate for each category for one of the ISPs observed (50%) from information and data provided by the IDTs. The IDT for Individual #276 did not consistently designate the	

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		appropriate risk level due to the inconsistent use of supporting clinical data when determining risks for some areas. For example, the choking risk was designated as medium in spite of the fact he had no history of choking or aspiration and the reason he was on chopped meat was due to his lack of cutting skills, not a risk for choking. Although this issue was brought up during the ISP, it was not documented on the IRRF. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in one (50%) of the ISPs meetings observed. The IDT for Individual #276 did not consistently have adequate and appropriate clinical discussions. ▪ Team disagreements regarding risk levels were noted in one ISP meeting for Individual #276 and were reconciled by the QDDP facilitating the ISP meeting. ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in both (100%) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team regarding Individual #290's ISP meeting included: ▪ Prior to the ISP meeting, Individual #290's team had populated the IRRF with the great majority of the information necessary to have an informed discussion about his risk levels. This facilitated the discussion, and, although the meeting was still long, it was a fairly efficient meeting with a lot of important information discussed, and decisions made. ▪ In addition to discussing the risks and related action plans, the team also discussed many other aspects of Individual #290's life. ▪ During the ISP meeting, the team for Individual #290 made a number of corrections to the IRRF. These corrections came from many different team members, and showed they had reviewed the draft IRRF. This resulted in a more accurate description of current status and supports. ▪ For Individual #290, the team reviewed and made necessary revisions to the PNMP after the risk rating discussion occurred. ▪ Generally, the QDDP did keep the team focused. The guardian, at times, diverted the conversation. He was on the telephone, making it more challenging to refocus him. However, overall the team remained on track. Also, other positive observations from the Monitoring Team regarding Individual #276's ISP meeting included: ▪ Individual #276's mother was able to attend the meeting via conference call and was frequently asked her opinion regarding team recommendations. ▪ Individual #276's team had completed the IRRF prior to the ISP. ▪ Some of the team members for Individual #276 were actively involved in the ISP process and very familiar with the individual.	

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		▪ The Speech Therapist on the team persisted in asking the team some important questions prompting team discussions. ▪ The Direct Support Professional present at the ISP was very attentive to the individual throughout the meeting. Problematic areas needing focus or improvement included: ▪ During the discussion about polypharmacy, the team for Individual #290 stated: "no side effects noted" for the five seizure medications and three medications for allergies. However, earlier in the team's deliberations, the team had expressed concern that he slept throughout his workday. Although there could be many reasons for his sleeping (e.g., bored with activities, not getting enough sleep, etc.), the team did not discuss the possible reasons, and particularly his medication regimen. ▪ During the ISP for Individual #276, there was considerable information that was found to be either erroneous or had not been communicated to some of the team members. For example, when discussing information regarding calorie counts, the dietician had not factored in the significant number of calories the individual consumed while at the canteen, making his calorie-restricted diet and calculated daily calories inaccurate. In addition, some of the team members kept referring to a "walking program," however, when researched, the individual was not on any such program. Consequently, some of the discussions regarding strategies addressing his significant weight issues were not actually occurring. ▪ The draft IRRF for Individual #290 included a number of important "current supports." However, the team did not verbally at the ISP meeting or in the final version of the ISP include these in the action plans or IHCPs. As a result, the IHCP was missing many important supports. Of additional concern was the lack of inclusion of supports identified for areas of low risk. Although the IHCP has been designated as the document in which medium and high risks will be identified, the ISP still needs to include the supports for low risks. ▪ The IRRF for Individual #276 did not include some very relevant clinical information in order to designate appropriate risk levels. For example, there were no glucose values or ranges included in his risk for diabetes. Also, there were no oxygen saturations listed related to his diagnosis of sleep apnea, significant weight issues, and noncompliance with his Continuous Positive Airway Pressure (CPAP) machine. ▪ In addition, the IHCPs for Individual #290 included a number of action steps referring to nursing protocols without any individualization. For example, he had an action step in his IHCP that read: "Nursing staff will follow seizure protocol if [Individual #290] displays seizure activity." This was unhelpful, particularly given that he had an active seizure disorder. ▪ In addition, the IHCP for Individual #276 did not include assessments that would	

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		be required by the nursing protocols for health issues such as cardiac disease and circulatory issues. ▪ For Individual #290, some clinical data and actions steps that the team discussed did not make it into the final ISP document. For example, with regard to the risk area of Osteoporosis, the team discussed his calcium intake, but it was not included in the final IRRF. Similarly, the action step the team discussed and included in the IRRF for the PCP to order and review current calcium levels to further inform orders related to calcium supplements was not included in the IHCP. ▪ The discussion of Individual #276's preferences and strengths was very limited and did not emphasize the fact he has the ability to read and write. Neither of these skills was integrated into his programing or activities during the ISP by the team. ▪ The IHCPs for Individual #290 did not include measurable clinical indicators to determine if the individual was remaining stable, improving, or experiencing negative healthcare outcomes. For example, for Individual #290, the goal for his risk areas of Seizures and Polypharmacy read: "To help prevent complications related to poly-pharmacy, and to prevent injury related to seizure activity AS EVIDENCED BY providing the supports identified in the action plans listed below." This provided the team with no mechanism to determine if the "supports identified and action plans" were working. This was an individual with an active seizure disorder. The team instead could have developed a measurable clinical indicator related to the reduction of seizures to a specific number (e.g., from 50 seizures this year to a specific number over the next year), or the duration of the seizures, etc. Without such an individualized clinical indicator, the team could not accurately measure over time whether or not the supports were working, or needed to be modified. ▪ The team for Individual #276 essentially added no measurable interventions addressing his weight that was 139 pounds over his desired weight range and a BMI of 50. ▪ For Individual #290, in the IHCP, the team did not focus on a number of important preventative actions beyond medications or the implementation of plans (e.g., the PNMP). For example, for constipation, the IHCP only included two action steps including direct support professionals documenting his bowel habits and reporting triggers to nursing staff, and nurses following the "nursing protocol" for constipation if he did not have a bowel movement in three days. None of this was preventative (e.g., assisting him to exercise, making sure he had access to and drank fluids, etc.). From the Monitoring Team's observations and record reviews, some positive steps were noted regarding the structure and format of the ISP meetings. However, more efforts are	

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		needed to ensure that the risk levels are accurate, that the IHCPs reflect the needed clinical intensity in alignment with the appropriately designated risk levels, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. In addition, 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 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.	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: The Facility's Self-Assessment for this provision indicated the following: ▪ The provider morning meeting appeared to be central to ensuring information concerning hospitalizations and decline in health status was communicated to the IDT in a timely manner. Post-hospital ISPAs were due back to the provider morning meeting for review. This provided a feedback loop to ensure the attentiveness of the IDT in reviewing new information and developing an ISPA. The Facility's Self-Assessment indicated that from a 20% (N=46, n=9) randomly selected sample of Change of Status ISPAs (every 5th hospitalization from the Hospital Visits reports) from 11/15/12 through 5/15/13, seven of nine (78%) of the IDT meetings occurred within five days of the individual being identified as being at risk; four of nine (45%) specifically discussed and made revisions to risk ratings and/or supporting documentation; and in nine of nine (100%), additional supports were implemented and/or current supports were revised to address the risk. Although the Self-Assessment contained overall compliance scores for much of the data, which as noted in previous reports did not lend meaning to the data, a number of graphs were included that did provide information by month regarding some of the Facility's findings, which was meaningful. However, regarding the above reported data, it was unclear to the Monitoring Team why hospitalization was the only indictor used to identify changes in status. In addition, interview with the Assistant Director of Programs indicated that much of the Facility's data was not based on the quality of the documentation. However, interview with the ADOP and review of the Facility's Self-Assessment indicated that the Facility was actively in the process of having the different disciplines begin to review discipline-specific assessment documentation in an attempt to begin the monitoring for quality issues. In order to ensure reliability regarding this process, specific criteria outlining the requirements for compliance will be needed in alignment with each discipline's standards of practice. ▪ In addition, the Self-Assessment indicated that from a review of 79 ISPAs from November 2012 through April 2013, for 69 (87%), the Morning Provider meeting attendees accepted the ISPA-recommended interventions/plans as	Noncompliance

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		clinically adequate (attendees included the Facility Primary Care Practitioners, pharmacist, dentist, OTs/PTs/SLPs, psychiatrist, psychologists, RNs, and QDDPs). Although this was a positive step forward regarding the monitoring of the interventions/plans generated at the ISPA meetings, there were no criteria provided that indicated what constituted "clinically adequate," or if the interventions/plans were actually implemented. ▪ Although the Facility Self-Assessment contained some promising data addressing the submission of required discipline assessments 10 days prior to the Individual Support Plan meeting, the lack of a percentage sample size (N/n) for each month and the use of overall compliance scores rendered most of the Facility's data addressing this area uninterpretable. However, the Facility did indicate that some disciplines had been identified as in need of improvement in this area, such as nursing which had experienced a number of staffing challenges since the last review. ▪ As mentioned previously, although some of the Facility's data were promising, a standard presentation format had not been established, and relevant information was not provided, such as the percent sample sizes and information regarding what specific criteria was used to determine compliance. In addition, most of the indicators the Facility used were not in alignment with the requirements of the Settlement Agreement, especially regarding the quality of the teams' identification of needed assessments, the completion of assessments, and the related documentation. <u>Self-rating</u>: The Facility reported that "based on the findings of the self- assessment this provision is not in compliance as evidenced by data indicating that changes of status were not acted upon within 5 days. Action plans are in place to address this concern." Also, for Section I.2, the Facility's action plans were broken into four sections. ▪ The first section involved implementation of the updated procedure addressing status changes and assessment requirements. It appeared the Facility was in the training phase. ▪ For the second section, the establishment of a communication process for IDTs regarding status change notifications had been implemented and was at the stage of monitoring the implementation. ▪ For the third section, ensuring the assessment process began within five days of risk identification was "in progress" or "in process." ▪ The fourth section focused on providing training to direct support professionals to identify changes in health status. This was part of the new employee orientation in-service training. Other areas such as the annual refresher and immediate retraining remained "in progress."	

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		In addition, an additional tracking sheet, labeled "DSP TOR" (treatment/order record), with in-services, was begun at the Facility in 2013. This provided a system of documentation for the various actions the direct support professionals completed for the individual. Additional information is discussed with regard to Section G.1, in which a sample of post hospital ISPAs was reviewed to determine timeliness of development. Eighty-eight percent of post-hospital ISPAs were developed within five days of the hospital discharge date. Based on a review of records for 23 individuals determined to be at risk (i.e., Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance), 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 did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators. As a result, it was unclear whether 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; ▪ When recommendations for further assessment were found on the Risk Action Plans/IHCPs, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was actually timely completed; and ▪ Some of the current IHCPs were missing from the Active Records. <u>Nursing Assessments</u> Based on a review of 23 individuals' records for which assessments were to be	

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		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 #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance. More specific details are provided with regard to Section M.2. In addition, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 23 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 health indicators in the Summary Section of the Comprehensive Nursing Assessment form. As noted in previous reports, nursing had no specific procedure in place addressing the process regarding the nursing assessments 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 in addressing the health risks of the individuals reviewed. In addition, regarding the Integrated Risk Rating forms, a review of these 23 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms and found that four (17%) included adequate included individual-specific information that clearly justified the risk ratings assigned (Individual #74, Individual #156, Individual #202, and Individual #51). Although the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, falls, injuries, and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that was assigned. <u>Medical Assessments</u> A review of six records for individuals determined to be at risk for several clinical areas (i.e., Individual #313, Individual # 114, Individual #283, Individual #74, Individual #284, and Individual #139) was completed. Based on this review, two of six (33%) included an adequate medical assessment to assist the team in developing an appropriate plan. The following are examples of clinical questions and concerns related to the quality of the assessments completed, outstanding concerns for which there was no information available in the submitted documents, and at times, inability to follow the clinical	

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		rationale in determining assessments and treatment options. Consistency and accuracy of information was also problematic in one of six charts reviewed: ▪ Individual #283 had been hospitalized three times from November 2012 through March 2013. Diagnoses provided included septic shock, aspiration pneumonia, and GERD for the first hospital admission; health care associated pneumonia and C. difficile colitis for the second hospitalization; followed by a return to the hospital one day after being discharged with bibasilar pneumonia for the third hospitalization. The individual required ventilator support during these hospitalizations. The individual had a gastrostomy tube (G-tube) placed in 2008, and had been treated medically for GERD, as well as with head of bed elevation. The individual received oral suctioning during tooth brushing. Of note, the individual was considered under ideal weight range, and had lost 30 percent of the individual's weight since April 2012. In response, the feeding rate had been increased since then to provide more nourishment and the individual was followed by the dietitian. The individual developed a stage two decubitus after the March 2013 hospitalization and the decubitus had healed by April 2013. There appeared to be a lack of information concerning further gastrointestinal work-up. Based on the submitted documents, there appeared to be no further consideration of whether GERD was a significant contributor to the aspiration pneumonia (i.e., was GERD worsening and contributing to pulmonary concerns), and there was no information to determine if this had been further evaluated as a cause for the individual's respiratory problems. Prior to these hospitalizations, the individual had an esophagogastroduodenoscopy (EGD) in 2011, which found a hiatal hernia. There was no test or test results indicating the severity of reflux. Since the more recent repeated pneumonias, there was no current evaluation to determine the presence or severity of reflux as a contributing comorbid condition. Considering the severity of the respiratory illness requiring ventilator support, ruling out worsening GERD might be an important step and might prevent recurrence if found to be a significant comorbid condition. Gastroparesis was also a concern, which did not appear to be evaluated. Increasing the feeding G-tube rate with gastroparesis and/or GERD might exacerbate the pulmonary concerns. If GERD or gastroparesis were contributing to reflux aspiration, then additional treatment options might need to be considered, including surgical options for severe GERD. A pulmonary consult of 2010 indicated the individual's continued risk of aspiration of saliva would require surgical intervention to reduce the risk. It was not clear from the documents if such intervention, with significant risks and benefits, was discussed with the IDT or the family/guardian, nor if there was documentation of discussion. If there had been discussion or decision, it was not in any	

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		submitted documents. If there was a family/guardian meeting concerning surgical options for the aspiration, it would be beneficial to ensure this remained available in the plan of care section of the annual medical assessment. The impact of environmental factors on the repeated respiratory distress did not appear to be reviewed. At the time of the ISP, the weight loss was treated with additional nutrition, and was believed due to the prior illness and hospitalizations. However, there did not appear to be any discussion in the IRRF concerning other potential causes of weight loss, no further assessments ordered, nor plans for further aggressive evaluation if further weight loss were to occur. In summary, it was difficult to track the completeness of assessments in resolving and preventing further repeated pneumonias. For an individual with repeated severe acute illness, there appeared to be significant gaps in assessment and whether more aggressive treatment options were indicated could not be determined. Additionally, there was little assessment of the significant weight loss, other than assuming it was due to hospitalizations. A plan was lacking for aggressive work-up should the weight loss or lack of weight gain continue despite increased nutrition. ▪ Individual #114 was hospitalized three times from November 2012 through January 2013. For the first hospitalization, the individual had hypoxia and lethargy, and it was believed the individual was postictal. The second hospitalization was for a health care associated pneumonia. The third hospitalization was for respiratory distress, bacteremia, and a urinary tract infection (UTI). The individual had a G-tube, and was known to silently aspirate nectar and honey thick liquids. The individual was nothing by mouth (NPO), but the IRRF also indicated that the SLP was following the individual with pleasure feedings of pureed food and honey thick liquids. The SLP documents were not reviewed to determine goals, risks, and benefits based upon known silent aspiration of honey thick liquids, or to determine if the SLP had implemented a program. The individual had severe gastroparesis from a June 2011 study. The feeding formula rate was intermittent. There was medication prescribed for the gastroparesis, and there was noted to be minimal gastric residuals at the time of feeding formula administration. There was a history of GERD, but the severity of the GERD did not appear to have been evaluated, based on submitted documents, to determine the severity of reflux as a contributing cause to aspiration, nor whether the intermittent feeding was refluxing due to GERD and gastroparesis. There appeared to be the need for further review of the individual's high-risk conditions in order to ensure appropriate treatment. ▪ Individual #284 had a long history of pica, requiring hospitalization and endoscopy in January 2013 to remove three gloves. There were numerous pica attempts in the past. The Level of Supervision (LOS), according to the 4/17/13	

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		ISPA, was enhanced at all times until asleep, and then 15-minute bed checks. The ISPA also stated that when there were three consecutive months in which there were no incidents of pica attempts or food foraging, the LOS would be reduced. Several staff were involved in pica sweeps and home monitoring each shift. There had been a liberalizing of the individual's diet to include increased caloric intake with snacks and liquid supplement. Despite the current LOS, the individual drank hand sanitizer on 5/5/13. There was no information concerning whether Facility Administration would be involved with the final decision process before reducing the LOS. Given the long history of pica and numerous incidents of ingestion of dangerous items (i.e., gloves that could result in death), there was no clear rationale documented to begin to reduce LOS based on less food foraging or pica attempts over a three-month period of time. It would be important for the IDT to review the LOS in place at the time of the prior pica attempts and events, and the length of time without a restricted LOS before a pica event occurred. As this individual had a long history of pica, the IDT needed to have a clear rationale written as to the reason for expecting the habit/behavior to remain resolved once the LOS was removed or reduced. With adequate LOS, the data might indicate the LOS worked, rather than the risk of pica had disappeared. Removing a successful plan, which included adequate LOS as a component potentially would place the individual at risk. Additionally, the current LOS might be inadequate due to the individual's ingestion of the hand sanitizer. ▪ Individual #139 had several challenging health conditions. This individual was hospitalized on 3/1/12 for hypoxia, UTI, aspiration pneumonia, and electrolyte imbalance; on 3/25/12 for vomiting and GERD; on 11/18/12 for asthma exacerbation and UTI; and on 6/20/13 for a health care associated pneumonia and sepsis with electrolyte imbalance. The individual was fed in an upright position, and remained upright for one hour after feeding. Oral care suctioning was provided. There was a diagnosis of restrictive lung disease and allergic rhinitis, and the individual intermittently required albuterol nebulizer treatments, and other medication as well as periodic oxygen (O2). Attention to head elevation while bathing was included in the physical and nutritional management plan (PNMP). The individual was tube fed and residuals were documented prior to formula feeding administration. The individual had a suprapubic catheter and a nursing protocol was identified for this. The individual had osteoporosis, and was given Miacalcin and Vitamin D, according to submitted information. Given the complexities of this individual's case, an endocrinology consult for alternative osteoporosis treatment might be indicated. The PCP did not attend all ISPAs with a medical focus, and the risk ratings needed further review. For instance, the IDT determined the individual was at low risk for fluid imbalance, yet the individual had two hospital admissions in	

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		which electrolyte abnormalities were found. The individual was considered low risk for infection, yet had risk of UTIs with the suprapubic catheter, and had a history of C. difficile infection in May 2013. The 5/16/13 ISPA did not address change in risk status for infection. The hospitalization for asthma exacerbation did not appear to be followed by a review of the environment for allergens (i.e., cleanliness of vents, location of bed near air conditioning units, housekeeping cleaning supplies, etc.), or review by the Respiratory Therapist concerning additional therapeutic options. The Active Problem List did not appear complete (e.g., the suprapubic catheter was listed under inactive problems), and neurogenic bladder, C. difficile infection, and asthma were not listed. The IDT depends on accurate, complete information in developing the IRRF, and the PCPs should ensure these lists are updated at intervals. In addition to the six active records reviewed, an ISP was reviewed for Individual #242. Focus was on the content and accuracy of the annual medical assessment, dated 3/27/13, as the IDT is dependent on current departmental assessments at the time of the ISP. The individual was NPO, with placement of a feeding-tube. But, in the most current annual medical assessment, under discussion of significant problems, for the diagnosis of oropharyngeal dysphagia, the condition was described as mild and the individual had been prescribed a ground diet texture and nectar thick liquids. The individual had been prescribed Coumadin in the past for a pulmonary embolism, but this had been discontinued by the pulmonologist on 9/5/12. The Active Problem List stated "History pulmonary embolism (2010), on Coumadin," which was not updated to reflect discontinuation of Coumadin. If this list were submitted in a transfer packet to the ER or community, inaccurate information could cause confusion, lead to unnecessary tests and delay in treatment or unnecessary/inappropriate treatment. The current list of medications confirmed the individual was not on Coumadin. However, in the plans and recommendations section of the current annual medical assessment, there was the plan to continue anticoagulation treatment. It is recommended that the Medical Department and or QA Department review accuracy and completeness of the annual assessments. Decisions made by the IDT based on outdated or wrong information will not lead to quality plans, nor health and safety of the individual. It was also noted, in review of the ISP assessments for Individual #242, that the copy of the annual dental summary submitted in the ISP packet appeared incomplete. This might have had to do with the template used, and such techniques as highlighting might not copy well. However, it appeared such routine information as oral hygiene, behavior, and periodontal condition had no information in the copy submitted. More problematic, as mentioned with regard to Section Q, was the fact that the annual dental summary	

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		submitted was dated 4/1/13, but was based on an annual exam dated 9/8/11, which was described as an attempt, with poor behavior. This outdated information likely would not benefit the individual or the team attempting to make current plans and recommendations. 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, 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.	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: ▪ The Facility's Self-Assessment indicated that a review of a 30% random sample (N=48, n=14) of ISPs from January 2013 through April 2013 found that one of 14 (7%) included evidence that the IHCP was implemented within 14 days; six of 14 (43%) IHCPs were available within the records; for one of 14 (7%), there was evidence that the IHCP was integrated into the ISP; in five of 14 (36%) there were action steps in the IHCP for high and medium risk ratings; in one of 14 (7%), the goals in the IHCPs were measurable; four of 14 (29%) included preventative steps in the IHCPs; four of 14 (29%) of the IHCPs included the identification of a person responsible for the monitoring; frequency of monitoring was clear in three of 14 (21%) IHCPs; and one of 14 (7%) included evidence that the monitoring was being conducted. Although the Facility indicated that the availability of the IHCPs (43%) in the active record impacted the monitoring results, the presentation of these data by month would have clearly identified any progress that had been made addressing these specific items. In response to these data, the Facility Self-Assessment indicated that the Facility would escalate the implementation of action plans for tracking completion and implementation of IHCPs. ▪ In addition, the Facility's Self-Assessment indicated that on 1/16/13, the QA/QI Council had deferred the Quality Assurance Department's monitoring for Section I due to pending changes in the risk process. The new/revised system was being implemented in stages across the Facility with full implementation set for April 2013 at which time QA Department monitoring would be re-evaluated. However, no additional information was included in the Self-Assessment addressing this issue. <u>Self Rating</u> The Facility's Self-Assessment indicated that "based on the findings of the self-assessment this provision is not in compliance as evidenced by data indicating that integrated health care plans were not consistently available and there was a lack of	Noncompliance

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		evidence of implementation within 14 days. Action plans are in place to address identified concerns." Regarding the Facility's Action Plans, there were three subsections for the action plan for Section I.3. ▪ The first section involved implementing the plan within 14 days. A monitoring system was reported to have been completed, but other steps such as obtaining the individual-specific training reports, reviewing a sample of the QDDP monthly reviews to determine implementation within 14 days, and QA monitoring of corrective action plans had not occurred. ▪ The second section involved implementing an Integrated Health Care Plan process. IDTs had been trained and mentored on this process, and this step was considered completed. Other steps such as training direct support professionals on the IHCP remained in progress. ▪ The third step was to ensure the IHCP was accessible in the active record. This step had not yet started. Based on a review of 23 records for individuals determined to be at risk (i.e., Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance), 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%). In addition, 19 individuals (83%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record. Individuals who did not have a related care plan included Individual #217, Individual #52, Individual #51, and Individual #130. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 19 Integrated Health Care Plans that were actually found in the Active Records included a date of implementation. However, 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	

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		in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage adequate fluids, 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 IHCP/Risk Action Plans into the ISPs in 19 of the 23 cases (83%). Individuals who did not have their IHCPs/Risk Action Plans in the Active Record included: Individual #217, Individual #52, Individual #51, and Individual #130. ▪ None (0%) of the plans reviewed 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 plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability or it was not addressed. At the time of the review, the Facility indicated that it was not in compliance with the requirements of this provision. This was consistent with the findings of the Monitoring Team. LBSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. These 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.	

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 7/10/13 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 6/13; o Reiss Screening Score Sheets and Comprehensive Psychiatric Assessments (CPAs) for Individual #269 and Individual #269; 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 10 individuals; o The following documents in the Presentation Book related to Section J of the Settlement Agreement: ▪ 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; o Spreadsheet of Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations; 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 The 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 7/11/13 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 Assessment; Annual Medical Summary, including the Active Problem List, Inactive Problem List, and Psychiatric Problem List; Hospital Admission section; Health Risk Assessment Rating – tool and team meeting sheet (only most recent); Psychiatry section, including the most recent Comprehensive Psychiatric Assessment; MOSES; DISCUS; Side Effects Screening section; Quarterly Drug Regimen Reviews (QDRR); 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 Monitoring Team's pre-review document request and considered to be psychiatrically stable: Individual #7, Individual #146, Individual #183, Individual #50, Individual #127, Individual #6, Individual #103, Individual #310, Individual #254, and Individual #82; o The same set of records was requested during the onsite review for the following individuals: Individual #30, Individual #320, Individual #233, Individual #68, Individual #213, Individual #126, Individual #79, Individual #8, and Individual #114; o Chemical restraint documentation for the following episodes where chemical restraint (and the dates of restraint) was administered: Individual #288 (3/3/13 and 3/10/13); Individual #51 (4/19/13); Individual #320 (3/7/13); and Individual #46 (3/7/13); o List of individuals who received medical pre-treatment sedation medication: 11/1/12 to 5/1/13; o List of "Oral Sedation Medication Given for Dental Appointments – Reporting Dates: 11/1/12 to 5/1/13; o Spreadsheet maintained by the Psychiatry and Psychology Departments to track the development of Desensitization Plans, as of 7/1/13; o Spreadsheet of individuals listing the status of CPA completion, through 7/1/13; and o MOSES/DISCUS side effect scales for the following six individuals who were prescribed

	Reglan: Individual #312, Individual #199, Individual #281, Individual #308, Individual #135, and Individual #324. ▪ **Interviews with:** o Dr. Richard Weddige, Director of Psychiatry; John McCullen, Psychiatry Assistant; and Shiraz Vahora, M.D., Staff Psychiatrist, on 7/8/13, 7/9/13, and 7/11/13; o James Forbes, Director of Psychology Services, on 7/8/13; o Dr. Russell Reddell, Director of Dental Services, on 7/8/13; o John Todd, R.PH., Clinical Pharmacist, on 7/8/13; o Dr. Richard Weddige, Director of Psychiatry and John McCullen, Psychiatry Assistant, on 7/10/13; o Sheila Powell, Human Rights Officer, on 7/10/13; o John McCollum, Psychiatric Assistant; Bob Robbins, Program Compliance Monitor; Dr. Richard Weddige; and Shiraz Vahora, M.D., on 7/11/13; o John McCollum, Psychiatric Assistant; Dr. Richard Weddige, Director of Psychiatry; and Ms. Ashley McCutcheon, Psychiatry Clerk, to review polypharmacy and presentation data, on 7/11/13. ▪ **Observations of**: o Polypharmacy Committee Meeting, on 7/8/13; o Morning Provider Meeting, on 7/10/13; o Pharmacy & Therapeutics Committee Meeting, on 7/10/13; o Psychiatric Clinics at 516 South Cedar (Fir), on 7/9/13; o Psychiatry Clinics on 527 North Cedar (Canna), on 7/11/13; o Neurology Clinic with Dr. Daniel Hurst, on 7/10/13; o Desensitization Committee Meeting, on 7/11/13; o ISP Meeting for Individual #276, on 7/9/13; and o During the Neurology Clinic on 7/10/13 and the visits to the residences and day/vocational programs at LBSSLC, the following individuals were observed: Individual #197, Individual #290, Individual #313, Individual #199, Individual #17, Individual #164, Individual #106, Individual #282, Individual #77, Individual #251, Individual #121, Individual #310, Individual #288, Individual #140, Individual #276, Individual #143, Individual #36, Individual #108, Individual #251, Individual #1, Individual #20, Individual #7, Individual #25, Individual #300, Individual #155, Individual #99, Individual #214, Individual #320, Individual #173, Individual #114, Individual #309, Individual #116, Individual #33, and Individual #175.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 6/12/13. 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 that the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. On 7/11/13, during the onsite review, these materials, including the Facility Self-Assessment, were reviewed with the

	Director of Psychiatry, the staff Psychiatrist, the Psychiatry Assistant, and the Program Compliance Monitor for Psychiatry. During that meeting, the methodology and results of the internal Facility reviews the Psychiatry Department performed were discussed in considerable detail. The team that completed the Quality Assurance reviews consisted of the Psychiatry Assistant and the Program Compliance Monitor assigned to the Psychiatry Department. At the time of the prior review, 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. In February 2013, the Facility began to utilize the new audit tool for Section J that the DADS State Office provided. At that time, the sample size was reduced to two individuals' records per month. This was in response to instructions from the State Office to review a sample of individuals on psychotropic medication every two months. This would constitute a sample of those individuals receiving psychotropic medication that would total at least 5% per quarter. An assessment of inter-rater reliability based on these two independent reviews was performed for both of these reviews each month. This monthly process resulted in 24 reviews per year, or approximately 20% of the individuals prescribed psychotropic medication. The data generated was reviewed quarterly in the Facility's Quality Assurance/Quality Improvement (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 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. o 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 finalized on 2/19/13. o 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 34 indicators, which collectively addressed 13 of the 15 provisions of Section J. The two sections not included were Section J.1 and Section J.5. However, the indicators in the tool primarily assessed for the presence or absence of specific items and did not adequately address the important factor of quality. For example, the new tool provided the prompt to ascertain if there was a psychiatric diagnosis or specific behavioral pharmacological hypothesis, but did not ask whether there was an appropriate description of the symptoms of that disorder. o The monitoring tool included adequate methodologies, which consisted of the review of 24 records per year (20% of the individuals prescribed psychotropic medications) by two independent reviewers, with an assessment of inter-rater reliability. o 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., 20% over a one-year period). These sample sizes were adequate to

	consider them representative samples. o The audit tools contained limited instructions and guidelines to promote consistency in monitoring and the validity of the results. The auditing tool did not come with a detailed instruction manual or guidelines. 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 the Psychiatry Department conducted of the audit results, 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 Director of Psychiatry. o The staff responsible for conducting the audits/monitoring appeared 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 through 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 to 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 (as discussed with regard to Section J.4); the MOSES/DISCUS completion-tracking spreadsheet (as discussed with regard 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. The Psychiatry Department also had begun to track the attendance of the individuals' Psychiatrists at their annual ISP meetings. ▪ 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 referenced 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 and/or psychiatric treatment. For example, the reviews checked for the presence of the psychiatric diagnosis, and the consistency of the diagnosis

	listed in different sections of the individual record. There was not a prompt in the tool to ascertain if there had been an adequate description of the symptoms of the disorder. During the onsite review, the Facility's auditors/monitors indicated that they did not check with reference material to ensure that the diagnosis met all of the necessary criteria for that diagnosis. o 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 relied on both their databases/spreadsheets, as well as the results of the internal audits. ▪ The Facility rated itself as being in substantial compliance with the following subsections of Section J: Sections J.1, J.2, J.3, J.5, J.6, J.7, J.11, J.12, J.13, J.14, and J.15. These findings were consistent with those of the Monitoring Team, with the exception of Sections J.8, J.9, and J.10, for which the Monitoring Team found the Facility to be in substantial compliance, while the internal self-assessment did not, and Section J.3 for which the Monitoring Team did not find substantial compliance. During the 7/11/13 meeting with members of the Psychiatry Department, they indicated that the reason for their rating of noncompliance with regard to Sections J.8, J.9, and J.10 was that they had limited data at the time the Facility Self-Assessment was prepared and had not yet concluded that efforts to attend the individual ISP Meetings had reached a threshold sufficient to constitute substantial compliance. Since that time, the Psychiatrists had continued to attend the ISP Meetings of individuals, and ensure that the necessary documentation was prepared and referenced in the ISP report. The additional reviews attended since May had increased their attendance to a rate that was approaching greater than 90 percent. There was also a discrepancy with regard to the Monitoring Team's rating of noncompliance for Section J.3, which was based on the review of the Chemical Restraint Data. Specifically, the Monitoring Team found that the Facility was not in compliance with this provision of the Settlement Agreement, due to deficits in the documentation contained in the Chemical Restraint Forms. These deficits are detailed in that section of this report. ▪ 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 process the Psychiatry Department performed independently of the QA/QI Department was the development and maintenance of the aforementioned specific databases.

	Summary of Monitor's Assessment: At the time of the Monitoring Team's previous review, LBSSLC had made substantial progress in a number of areas related to Section J. One area of improvement included standardization of the process for completing Comprehensive Psychiatric Assessments in a timely manner, consistent with the specifications of the Settlement Agreement. There had also been considerable progress in decreasing the rates of polypharmacy that could not be clinically justified, and this was sustained. The Psychiatry Department continued to employ two full-time Psychiatrists, as well as a part-time Consulting Psychiatrist. Both a full-time Psychiatry Assistant and a Psychiatry Clerk supported the Psychiatrists. The clerical position was added to assist in the gathering of historical information needed to justify the psychotropic medications for the individuals in the Stable Polypharmacy group, as well as maintaining the various databases/spreadsheets needed to sustain their progress for a number of the provisions of the Settlement Agreement. A significant remaining issue at the time of the Monitoring Team's previous review was the participation of the Psychiatry Department in the ISP process, as reflected in their participation in the annual meeting and the contributions to the corresponding written documentation. The Monitoring Team's prior report stressed the importance of addressing this issue, which directly affected the requirements of three of the provisions of the Settlement Agreement (i.e., Sections J.8, J.9, and J.10). The current review found that the Psychiatry Department, working in conjunction with the other members of the Interdisciplinary Team, had developed a systematic approach to addressing these issues, while maintaining the progress they had previously made in other areas.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Richard Weddige, Director of Psychiatry, was Board Certified in Psychiatry by the American Board of Psychiatry and Neurology. He served on the Faculty of Texas Tech University Health Sciences Center School of Medicine, Department of Psychiatry in a full-time capacity for 27 years. He retired from this position 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 twelve years. The Facility had continued to contract 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 needed. At the time of the Monitoring Team's prior onsite review, his primary role was to contribute to the initiative to update Comprehensive Psychiatric Assessments. In the course of updating 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	Substantial Compliance

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		residences, and the day and vocational programs. At the time of the Monitoring Team's prior review, 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 contract 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. LBSSLC recently hired a new full-time Psychiatrist, Shiraz Vahora, MD. Dr. Vahora was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, as well as the sub-specialties of both Geriatric and Forensic Psychiatry. He had worked in correctional psychiatry for the last several years. However, during this time, he continued to work on a part-time basis for the state Mental Health/Mental Retardation (MH/MR) clinical 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, including many who had Intellectual Disability/Developmental Disability (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 123 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 review included 19 individuals, or 15 percent 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 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 Monitoring Team's 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	Substantial Compliance

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		the individuals prescribed psychotropic medication. The Department of Psychiatry maintained data related to its progress in completing the CPAs for those individuals who received psychotropic medication. Review of this spreadsheet entitled: "Psychiatric Assessments (Active List)," indicated that an updated (i.e., completed, or reviewed and/or revised within the last 12 months) CPA had been completed for all (100%) of the individuals who were prescribed psychotropic medication. The review of the records of 19 individuals prescribed psychotropic medication indicated that all (100%) of the records 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. The spreadsheet included a column for the most recent date that a revised CPA was performed. All of the dates in this column were less than one year ago. 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 (100%) of the 19 individuals in the sample, contained adequate documentation to justify the 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 Reviews, and Psychiatric Consultations) was 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 prior reviews had identified a significant problem related to the identification of behaviors 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 with regard to	

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		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 34 (28%) individuals prescribed psychotropic medication. 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 reviewed indicated there was an active Positive Behavior Support Plan (PBSP) for each individual who was prescribed psychotropic medication. The Monitoring Team's initial reports noted that the behaviors 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 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 (100%) individuals receiving psychotropic medication. Any concerns related to the quality of PBSPs are discussed with regard to Section K.9 of the Settlement Agreement. As discussed in the Monitoring Team's previous reports, the use of chemical restraint	Noncompliance

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		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 #288 (Episode A) / 3/10/13 / 12:52 p.m. / Ativan 2 milligrams (mg) IM Individual #288 (Episode B) / 3/3/13 / 8:53 p.m. / Ativan 2mg IM Individual #51 / 4/19/13 / 4:30 a.m. / Zyprexa 10mg with Benadryl 50mg IM Individual #320 / 3/7/13 / 12:30 p.m. / Ativan 2mg IM Individual #46 / 3/7/13 / 6:58 p.m. / Haldol 10mg and Ativan 2mg IM The restraint data was reviewed for the presence and quality of the five components of documentation 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 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 (100%) of these individuals. However, the documentation for Individual #288 (Episode A) indicated that this individual was aggressive and agitated prior to restraint, but did not describe the specific antecedent events. Specifically, the information in this section stated, "[Individual #288] had been physically aggressive toward staff, hitting/kicking and head-butting. [Individual #288] had been 3x standing basketholdreleased still showing signs of aggression. Chemical restraint implemented/injected at 12:43 p.m." This did not detail the specific behaviors that resulted in the need for chemical restraint to demonstrate that at the time of the chemical restraint he was exhibiting behaviors that presented a danger to self or others. ▪ 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, and the documentation was completed adequately for all five (100%) individuals.	

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		▪ The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for four of the five (80%) individuals in this sample. The exception was Individual #320, for whom the entries stated only "off of home." ▪ The face-to-face post-restraint debriefing was completed for all five (100%) individuals. ▪ The Chemical Restraint Clinical Review Form was completed for all five (100%) of these individuals in a timely manner. Each of the five Clinical Review Forms contained comments by the Pharmacist and Psychiatrist related to the appropriateness of the pharmacological intervention. However, for two of the five individuals (Individual #46 and Individual #320) the comments of the Psychiatrist were minimal. They consisted of only brief statements that the medication was appropriate, and there were no interactions with other existing medications. There were no comments that were related to the specific situation and what if anything might be done pharmacologically to prevent a similar event in the future. Thus, the essential five elements of the documentation needed to verify the appropriate utilization of chemical restraint were adequately completed for two of the five (40%) individuals in this sample. The Facility had made 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 general behavior that precipitated the restraint, 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 general problematic behavior that precipitated the need to utilize chemical restraint. The only individual, for whom this detail was not present in this sample of five recent administrations of chemical restraint, was that of Individual #288 (Episode A), for whom this section only described the general behavior that precipitated the chemical restraint. 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 conclusion is based on the finding that the documentation in the Chemical Restraint data was not uniformly sufficient to ensure that there are not instances where chemical restraint might have been	

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		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 Pharmacist and the Psychiatrist provided another such opportunity to ensure that the documentation provided 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 7/11/13. The column that included a listing of individuals with a notation that they had a Rights Restriction for dental sedation contained 115 individuals' names. Pre-treatment sedation for medical procedures was required for 23 individuals, as compared to 41 at the Monitoring Team's last review. Only two individuals were listed as requiring pre-treatment sedation for medical procedures, but not also for dental procedures. The total of these numbers exceeded 115 due to several individuals who required consent for more than one type of procedure. For example, the Director of Dental Services pointed out that some overlap existed within the two categories of pre-treatment sedation and general anesthesia for dental procedures, because some individuals only required pre-treatment sedation for dental hygiene interventions, such as cleanings, but required general anesthesia for more invasive procedures, such as extractions. However, this degree of clinical specificity was not noted on the spreadsheet and, thus, the numbers cited above could not be mathematically reconciled. During the Monitoring Team's onsite review, a request was made for the actual utilization data regarding the use of pre-treatment sedation for medical procedures for the last six months. The data presented in response to this request was entitled: "List of individuals who received pre-treatment for medical procedures during the last six months." The document listed 16 individual administrations of medication for medical procedures. The most frequently utilized agents were Ativan and Zyprexa. Ativan was prescribed at a dosage of two milligrams given either by mouth (PO), or intramuscular injection. The corresponding dosage for Zyprexa or Zydis (Zydis is the rapidly dissolving sublingual form of Zyprexa), was 10mg either PO or IM. Two individuals were prescribed Ativan 2mg PO/IM and Zyprexa 10mg PO in combination. These dosages were within a range that is commonly considered to be reasonable and safe.	Noncompliance

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		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 presented in response to this request was entitled: "Oral sedation given for dental appointments reporting dates: 11/1/12 – 5/20/13." This document contained information regarding one individual who received one administration of pre-treatment sedation in the form of Ativan 2mg PO, for dental procedures during this time period. The route of administration was not identified on the spreadsheet, but during the 7/8/13 interview with the Director of Dental Services, he stated that it was oral, and that all dental pre-treatment sedations were oral. He also indicated that the Director of Psychiatry would be consulted whenever an agent other than Ativan was utilized. However, these consultations were usually verbal, informal consults that were not documented. At the time of the 7/11/13 meeting of the Desensitization Committee, it was reported that there were currently 115 active Desensitization Plans for dental procedures and 24 such plans for medical procedures. However, the extensive discussion that occurred during this meeting indicated that the Facility was revising the criteria regarding which individuals will require a Desensitization Plan. This was initially being carried out in conjunction with the DADS State Office. It is anticipated that this will lead to a significant reduction in the number of Plans required. The scope of the potential revisions discussed in the 7/11/13 meeting were so extensive that the Facility is essentially developing a new approach to the issues discussed in this provision, which will require significant revisions to the processes that had been developed over the past three years. It is also not clear at this point in time that those revisions will be consistent with the requirements of this section of the Settlement Agreement, because the changes that the Facility was proposing would essentially change the criteria for which individuals required a desensitization treatment plan in a manner that had not yet been fully defined. In addition, as discussed with regard to Sections C.4 and S.1, the skill acquisition programs that had been developed to reduce to the extent possible the need for pre-treatment sedation still required significant work. Accordingly, the finding of noncompliance was carried forward from the prior review.	
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	At the time of the Monitoring Team's prior review, the Director of Psychiatry had completed an analysis of the time commitment required of the Psychiatry Department to provide ongoing, routine psychiatric services to the individuals at LBSSLC, including fulfilling 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 other ongoing day-to-day psychiatric	Substantial Compliance

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	necessary for implementation of this section of the Agreement.	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. On 7/8/13, this subject was again discussed with the members of the Psychiatry Department. As indicated with regard to Section J.1, the number of full-time Psychiatrists continued to be 2.1 full-time equivalents (FTEs), and the workload was essentially the same as it was at the time of the Monitoring Team's last review. At the time of the Monitoring Team's current review, LBSSLC employed two full-time Psychiatrists. A total of 123 individuals were receiving psychotropic medications. Thus, each of the full-time Psychiatrists was responsible for the psychiatric care of approximately 60 individuals. The Facility continued to employ the part-time Psychiatrist that had been added for four hours per week prior to the Monitoring Team's previous review. This Psychiatrist did not have an active caseload of individuals, but rather, his time was devoted to performing second-opinion consultations, and annual updates of the CPAs. In addition to Staff Psychiatrists, the Facility also employed one full-time Psychiatry Assistant to help coordinate the psychiatric care of the 123 individuals prescribed psychotropic medication. The Facility had also added a full-time Psychiatry Clerk to assist with the data collection related to meeting the requirements of the Settlement Agreement. Thus, the total composition of the Psychiatry Department at LBSSLC continued to provide sufficient resources to meet this requirement of the Settlement Agreement. The Facility was found to continue 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.	The Facility had maintained the initiative to complete a thorough CPA for each individual receiving psychotropic medication that 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 (100%) individuals in the sample that met the formatting requirements specified in the Settlement Agreement. CPAs that had been completed within the last year, and met the criteria identified in the Settlement Agreement, were found for all of the 19 (100%) individuals included in the sample of 15 percent of individuals prescribed psychotropic medication. 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.	Substantial Compliance

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		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. The spreadsheet the Facility maintained, to track the status of the completion rate of the CPAs, identified 126 individuals, which exceeded the current number of 123 individuals receiving psychotropic medication. However, there had been individuals who were discharged into the community, as well as new admissions over the past several months, which accounted for the minor discrepancy in the numbers. The spreadsheet indicated that there were no individuals for whom an updated annual CPA was overdue. Accordingly, LBSSLC was found to remain in substantial compliance with this provision, based on the representative sample of records reviewed during both the Monitoring Team's 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 100 percent 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 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.	This provision of the Settlement Agreement 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 Monitoring Team's 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. The Monitoring Team's initial reviews indicated the Reiss Screenings were first administered in the 2008 to 2009 timeframe, and had not been updated. At the time of the Monitoring Team's prior review, the Director of Behavioral Services indicated that 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 updated in June 2013, indicated that in the month of July 2012, the Reiss Screen instrument was utilized to assess the behavioral status of all such individuals. The summary that preceded the spreadsheet in the Presentation Book contained the following information: "Since the last court monitoring visit, all individuals who do not receive	Substantial Compliance

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		psychotropic medications received a Reiss Screen for Maladaptive Behavior. These assessments were electronically scored and the information was sent to the individuals' records for review. As of 06/20/2013, the population of the [LBSSLC] was 213. There were 126 individuals receiving psychoactive medications and 87 who required a Reiss Screen." As noted above, LBSSLC 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 Facility's choice to conduct 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 but one of the individuals admitted to the Facility in the last six months were prescribed psychotropic medication at the time of admission, and, thus, were evaluated with a CPA. These individuals also continued to be followed in the Psychiatry Clinics. The exception to this was Individual #71, who was administered the Reiss on 2/27/13. This individual was not receiving psychotropic medication at the time of the admission on 1/29/13, but had a prior history of active treatment with psychotropic medication. Accordingly, this individual was administered both a Reiss Screen and a CPA. The Reiss Screen was administered as part of the evaluation process and yielded a total score of zero. On 1/31/13, the CPA was performed and conformed to the requirements of the Settlement Agreement. The CPA indicated that the individual was psychiatrically stable and concluded that there was no reason to resume treatment with psychotropic medication. The Psychiatry Department indicated they also included an evaluation with the Reiss Screening instrument for any individual for whom they were asked to perform a Psychiatric Consultation, as they had done in the past. On 6/6/13, the Reiss Screen was administered to Individual #269 as part of a Psychiatric Consultation that had been requested by the Psychology Department. The results indicated that the score was below the clinical cut-off of nine. The CPA related to this consultation was dated 5/21/13, and conformed to the requirements of the Settlement Agreement. The CPA recommended that the individual be started on Risperidone 0.5mg twice a day, which had been beneficial in the past. The CPA also recommended that the Reiss Screen be performed, which subsequently occurred, as noted above. This individual continued to be followed in the Psychiatry Clinic.	

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		Accordingly, the finding of substantial compliance was carried forward from the Monitoring Team's prior review. During the Monitoring Team's 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 Clinics conducted by both Psychiatrists, where it was apparent that the Staff Psychologist had a central role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The data was available in both tabular and graphic formats and was discussed during the course of the meeting. There was also a discussion of interpersonal and environmental 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 Clinics on 7/9/13 and 7/11/13 were 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 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 of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the 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 the Psychiatry and Psychology Departments had made in rectifying these problems. The primary disciplines that attended the Psychiatric Clinics were Nursing, Psychiatry,	Substantial Compliance

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		Psychology, direct support professionals, and the QDDP. Disciplines such as Speech Therapy, Occupational Therapy, and Physical Therapy were 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 ISP meeting for 17 of the 19 (89%) individuals. The only records that did not contain this documentation were those of Individual #183 and Individual #68. However, it should be noted that the ISP documentation for Individual #68 indicated that the Psychologist and Nurse Case Manager discussed the aspects of the individual Psychiatric Treatment Plan that would otherwise have been reviewed by the Psychiatrist. On 7/9/13 members of the Monitoring Team attended the ISP meeting of Individual #276, and directly observed the Psychiatrist's attendance and participation in the ISP process. The Psychiatrist provided an overview of the individual's clinical status, and the rationale for the current prescribed psychotropic medication. There was also a discussion of the risks presented by the side effects of these medications, as well as the clinical benefits. At the time of the Monitoring Team's prior review, the members of the Psychiatry Department had begun an initiative to attend the ISP meetings, but in the records reviewed, none (0%) of the documentation from these meetings adequately reflected the psychiatric aspects of the individuals' treatment. 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 there any mention of the contributions to the meeting the member of the Psychiatry Department made. Integration of psychiatric supports with other supports was not evident in the individuals' ISPs. At the time, the Facility had just begun to use the new format for the ISP that included a separate subsection to specifically discuss the psychiatric aspects of the individual's care. It was hoped that with this addition, teams would both discuss and document the psychiatric treatment plan in more detail. In addition, the revised Integrated Risk Rating Form (IRRF) included a section on "Behavioral Health" that was intended to combine psychological and psychiatric information. The data maintained by the Psychiatry Department indicated that, during the timeframe of October 2012 through May 2013, a member of the Psychiatry Team had been able to attend the ISP for 85 of the 94 (90%) individuals who were prescribed psychotropic medication and also had an ISP in this timeframe. As noted above, the documentation in the records reviewed was significantly improved. The process that had contributed to	

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		this improvement included the completion of the Psychoactive Medication Treatment Plan (PMTP). This document contained the following sub-headings, which described the material contained in that section: ▪ Demographic Information; ▪ Psychiatric Diagnosis; ▪ Symptoms of Diagnosis; ▪ Target Symptoms Monitored; ▪ Psychological Assessment; ▪ Combined Behavioral Health Review/Formulation (which contained sub-headings for Biological, Psychological, and Functional Derivation of Behaviors); ▪ Psychoactive Medication (which contained the description of the medication, including the rationale for its use, and both the realized and potential side effects); ▪ Risk of Medication (which described overall risk presented by the medication); ▪ Risk of Illness (which described risk of harm to self or others presented by the illness); ▪ Non-pharmacological Treatment (which described behavioral and other non-pharmacological interventions that would be considered less intrusive); ▪ Risk Versus Benefit Discussion (which included overall discussion of the risk-versus-benefit equation); ▪ Past Pharmacotherapy (which described the results of past trials of psychotropic medication); and ▪ Future Plans (which described future plans regarding medication, as well as a community placement discussion). These documents were fully completed for each individual in the sample of 15% of the individuals prescribed psychotropic medication. The completed documents ranged in length from two to three pages. The plans began with the notation that they were being specifically prepared for the individual's ISP meeting. In addition, it was noted at the beginning of each plan they were not intended to be stand-alone documents and that additional information could be found in the individual's most recent annual Comprehensive Psychiatric Assessment. The date that the CPA had been prepared was also referenced to facilitate the IDT's recognition of that document. In addition to the PMTP, the Psychiatry Department, working in conjunction with the Department of Behavioral Services, also submitted the completed Behavioral Health section of the IRRF to the QDDP as part of the ISP preparation packet. The Polypharmacy section of the IRRF was also completed, if applicable. The new format for the "Behavioral Health" section integrated both the psychiatric and psychological treatment plans, and was formulated through collaboration of the two Departments.	

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		The topics and sub-headings of the "Behavioral Health" section of the IRRF were as follows: HISTORY (INCLUDING HISTORICAL DATA IF APPLICABLE): Psychiatry Behavioral Health CURRENT SUPPORTS: Psychiatry Behavioral Health CURRENT STATUS (INCLUDING EFFECTIVENESS OF PROGRAMS/SUPPORTS AND CURRENT DATA): Psychiatry Behavioral Health PROPOSED RECOMMENDATIONS/RATIONALE (INCLUDE ANTECEDENTS, TRIGGERS, ETC.): Behavioral Health Psychiatry TEAM DELIBERATIONS AND FINAL RECOMMENDATIONS/CASE FORMULATION: Consideration of the Use of Restraint RISK RATING (INCLUDING RATIONALE FOR RATING): The PMPT was specifically noted in the ISP documentation so that it could be readily located in the individual's record, but was not actually reproduced verbatim, although a summary of the information was provided. The PMPT also provided a stimulus for the discussion of the issues by the Psychiatrist during the annual ISP Meeting. This review indicated that the efforts of the Psychiatry Department to attend the annual ISP meetings on a regular basis had been implemented and were successful. The material contained in the CPAs, the documentation in the Psychology sections of the record identified above, the information contained in the PMTP, and the combined Psychology/Psychiatry sections of the IRRF clearly indicated that there was integration of psychiatric and behavioral services at LBSSLC. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
J9	Commencing within six months of the Effective Date hereof and with	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	Substantial Compliance

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	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.	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 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 Functional Analysis 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 records for 19 individuals prescribed psychotropic medication indicated the Facility had effectively rectified this problem through combined assessment and case formulation. None of the records included 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 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 the Monitoring Team 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	

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		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 CPAs also contained a more detailed discussion of this topic in the sub-heading "Bio-Psycho-Social-Spiritual Formulation." At the time of the Monitoring Team's prior review, it was noted that although LBSSLC had effectively rectified the aforementioned problems in the individual records, there continued to be 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 had been significantly improved through the utilization of the PMTP, which was submitted to the QDDP as part of the pre-ISP planning process, and was then referenced in the ISP. During the onsite review the members of the Psychiatry Department indicated that the individuals who actually prepared the final ISP documentation could not accommodate the inclusion of the detailed documentation described in this section of the Settlement Agreement due to concerns about length. The Department also did not want to place the burden of summarizing this complex clinical information upon the QDDP staff that prepared the final ISP documentation. Accordingly, the Department had developed the PMPT, the contents of which are detailed above. As also noted in the narrative discussion related to Section J.8, this document also referenced the current annual CPA, which contained even more detailed information. This was seen as a reasonable compromise to extending the length of the ISP, which in the end could be nonproductive, while also keeping the responsibility for the content of this material within the hands of the Psychiatry Department. As detailed with regard to Section J.8, the documents referenced in the ISP were designed to address the specific requirements of this provision as per the recommendations that had been contained in the Monitoring Team's prior report related to this provision. Accordingly, the referenced supporting documents contained detailed descriptions of the rationale for the use of psychotropic medications and the considerations that went into those decisions. This information also included a discussion of whether psychotropic medication represented the least intrusive and most positive intervention, and also identified the role of behavioral and/or programmatic interventions that were also being utilized. The PTMP also included a section that discussed the Psychiatrist's thoughts on the question of future community placement based on the impact of their psychiatric	

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		disorder as well as their clinical stability. As indicated with regard to Section J.8, the Psychiatrists had begun to routinely attend the ISP meetings. The discussion in Section J.8 indicated that in the review of 19 individual records contained in the sample, 17 of the 19 (89%) individuals' records showed that the Psychiatrist had attended the ISP meetings, and the ISP documentation for all of these individuals contained evidence of the collaboration between the Psychiatry and Psychology Departments. The same methodology was employed to assess for the presence of the specific factors addressed in this provision as reviewed above. This review found a discussion of the required elements in the ISP and/or the additional documents referenced in the ISP. In addition, the Psychiatry Department's internal tracking system indicated that during the 10/12 to 5/13 timeframe, a Psychiatrist had attended 85 of the 94 (90%) ISP meetings of individuals prescribed psychotropic medication. Thus, there was evidence that the Psychiatrists had been routinely attending the ISP meetings of the individuals prescribed psychotropic medication for the past several months. The assessment of the documentation that was both contained in and referenced in the ISP is based on the review of the sample of 15% of the individuals prescribed psychotropic medication. This was considered a sufficient sample on which to base this conclusion, because there was little variability in the quality of the content. This suggested that the Facility had developed and implemented an effective system to address these issues. The Monitoring Team's previous review documented adequate collaboration between the disciplines of Psychiatry and Psychology, but found the Facility in noncompliance with this provision because the Psychiatrist had not attended the ISP meetings of a sufficient number of individuals, and the ISP documentation did not provide evidence of the collaboration between the two Departments. As detailed above, the Facility had now effectively resolved both of those issues and, thus, was found to be in substantial compliance with the provision of the Settlement Agreement.	
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	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The Monitoring Team's initial 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 HRC section of the record, as well as the PBSP. However, additional discussions of this subject had been	Substantial Compliance

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	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.	added in the Bio-Psycho-Social-Spiritual sub-section of the CPA, as well as the "Psychiatric Consultation – Diagnostic and Treatment Analysis," which contained a specific sub-section on "Risk vs. Benefit." In the months following the Monitoring Team's previous review, the Psychiatry Department, working in conjunction with the Department of Behavioral Services, had developed and implemented the "Psychoactive Medication Treatment Plan," which was specifically designed to provide comprehensive information needed to provide an overview of this aspect of the individual's Treatment Plan for their annual ISP. This information contained the following: "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." The sub-sections of this document are described with regard to Section J.8. 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, also 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. The Monitoring Team's current review found an adequate discussion of the risk-versus-benefit analysis in all of the 19 (100%) individual records contained in the review sample. 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. These discussions and the related documentation appeared in the CPAs, the PMTP, the Quarterly Review forms, the Polypharmacy section of the IRRF, and the newly formatted Behavioral Health section of the IRRF, which was produced through collaboration between the Psychiatry and Psychology Departments. A key factor in determining if the use of psychotropic medication represented the most effective and least intrusive intervention relates directly to the derivation of the target behavior from biologically determined factors, behavioral sources, or a combination of both. Elements of this discussion were contained to varying degrees in each of the documents described above. There is further discussion of these processes below with regard to Sections J.13 and J.14.) A member of the Monitoring Team interviewed the HRC Officer on 7/10/13. The reviews of the Committee Meetings observed during the Monitoring Team's previous onsite	

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		reviews were very detailed, and are described in those reports. There were instances in which the HRC rejected behavioral plans because of insufficient information. The interview with the HRC Officer, as well as the review of the minutes from prior meetings, indicated that these observations continued to be accurate. The Facility was determined to be in substantial compliance with this section of the Settlement Agreement, based on: 1) the presence and quality of the risk-versus-benefit discussions; and 2) the quality of the HRC reviews.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	This provision relates to the degree of inter-class and intra-class polypharmacy, as well as the attempts to reduce polypharmacy. LBSSLC had maintained tabular data that illustrated the yearly reductions in the rates of polypharmacy, dating back to 2005. This data clearly illustrated a consistent, marked reduction in the rates of polypharmacy. The current version of this document illustrated continued progress in reducing the frequency of polypharmacy with psychotropic medication. The following summarizes 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 four since that time – with the current frequency of four. 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 eight since that time – with the current frequency of eight. 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 compilations indicated this number had been reduced to 15, and the current number was 17. ▪ 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 seven reporting periods, including 10/12. However, as of 7/13, this number was five. ▪ 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 three, which was less than the four reported after the Monitoring Team's 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 five reviews. It should be noted that the sum of the numbers of individuals described in the discussion	Substantial Compliance

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		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 1/13 to 7/13 indicated that a thorough review of each of the individual's prescribed polypharmacy with psychotropic medications occurred each month. The professional staff who routinely attended these meetings were as follows: the Medical Director, Clinical Pharmacist, Director of Psychiatry, Program Compliance Monitor for Psychiatry, the Psychiatric Assistant, the Psychiatry Clerk, and the Staff Psychiatrist. On 7/8/13, a member of the Monitoring Team observed the Polypharmacy Committee Meeting. Team members indicated that the format and content of this meeting was representative of prior meetings, and included a brief clinical review of each individual whose psychotropic medication regimen met the criteria of polypharmacy. The format of the meeting was also similar to those 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 individuals' medication, as well as determine which of an individual's current medications were considered to be essential to their stability. LBSSLC had continued to admit individuals from community-based residential programs and/or psychiatric hospitals that, 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 that 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 5/12 was receiving five psychotropic medications at that time and was receiving only one at the time of the Monitoring Team's most recent onsite review. During the Monitoring Team's prior reviews, the Facility reported that the Psychiatry team believed the current medications were justified for a number of individuals, and without them, the individuals' psychiatric status would deteriorate significantly. The	

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		terminology contained in this provision of the Settlement Agreement 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 being made to decrease one or more of their psychotropic medications, and "Stable – Polypharmacy" 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 7/8/13 Polypharmacy Committee Meeting, the data presented was organized 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 eight (7%) of the total 123 individuals receiving psychotropic medications. However, it should be noted that six of these eight (75%) individuals were receiving only three psychotropic medications. ▪ As of the 7/8/13 meeting, there were four individuals in the New Admission category, with a range of four to five medications still present. ▪ The third category labeled "Stable Polypharmacy" 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 123 individuals receiving psychotropic medications) the Facility staff believed met these criteria. Accordingly, a member of the Monitoring Team performed a detailed review of the evidence 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 two individuals: Individual #299 and Individual #140. The data presented in the justification for the other 14 (88%) 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	

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		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 7/8/13 Polypharmacy Committee Meeting, 28 of the 123 (23%) individuals who were prescribed psychotropic medication at LBSSLC met the criteria for polypharmacy. ▪ Eight of these 28 individuals (29%) had been placed in the "Active" category, which meant that the Psychiatry Team was still actively addressing the individual's medications. o Five of these individuals had been admitted to the Facility in the 2010/ 2011 time period 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 Three 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 #320, Individual #33, and Individual #25. These individuals had complex, difficult to treat psychiatric disorders and the Psychiatry Team was still actively adjusting their medications. ▪ There also were four (14%) individuals in the "Active – New Admissions" category who had been admitted within the last year. Thus, the Facility was still engaged in the process of challenging their medications, as noted above. ▪ The final category of "Stable" polypharmacy included 16 individuals (57%) for whom the Facility had determined that their psychotropic medications could be justified. 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 14 of the 16 (88%) individuals. This justification was not present for Individual #140 and Individual #299. This appeared to primarily be due to a lack of information in the prior records. Thus, if one accounts for the four individuals who were admitted to LBSSLC from the community on multiple psychotropic medications within the last year, and the 14	

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		individuals for whom the empirical evidence was sufficiently detailed to support the contention that their prescribed medications were necessary, there remained 10 individuals. Eight of these individuals were from the "Active" category and two were from the "Stable" category. Current justification for their psychotropic medications could not be determined. This equated to eight percent of the 123 individuals receiving psychotropic medication. These individuals were not noted to be experiencing any noticeable side effects from their medications. With regard to the two individuals identified from the "Stable Polypharmacy – Clinically Justified" 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 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 eight individuals in the "Active" category were not stable, and presented with complex psychiatric disorders, and the Facility was actively working to adjust their medications to improve their quality of life. The Facility was found to remain in substantial compliance with this provision, as they continued to actively assess the individuals' 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 eight 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 requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale (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 (per the Healthcare Guidelines). 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 the Monitoring Team's previous reports, the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination. The review of the sample of the records for 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 (100%) individuals.	Substantial Compliance

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		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 (100%) of these individuals. 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 (100%) of these individuals. The prescribing practitioner had reviewed and signed all (100%) of the completed DISCUS evaluations in the sample records within 14 calendar days of completion. The DISCUS and MOSES also were 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 six of the 22 (27%) individuals fitting the above criteria was selected: Individual #312, Individual #199, Individual #281, Individual #308, Individual #135, and Individual #324. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for all (100%) of these six individuals. The documentation had also been reviewed and signed by the prescriber in a timely manner for all six (100%) individuals. The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated these evaluations were completed as specified for five of the six (83%) individuals. Individual #308 was missing documentation, because only one DISCUS evaluation (dated 5/12/13) could be located in the record. The prescribing practitioner also had uniformly reviewed and signed these evaluations in a timely manner for all (100%) of these individuals in the sample. The review of the overall completion rate of the MOSES every six months, as specified in the Settlement Agreement, indicated these evaluations had been carried out as specified for all (100%) of the individuals in the overall sample of 19 individuals receiving psychotropic medication, as well as all six (100%) individuals prescribed Reglan who were in the sample of individuals prescribed Reglan and were also not receiving any psychotropic medication.	

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		The assessment of the timely review of these documents by the prescriber indicated that the review had been completed within 14 days for all (100%) of the individuals in the sample of 19, and all (100%) of the six individuals in the sample who were receiving Reglan. A similar analysis of the assessments related to the administration of the DISCUS every three months indicated that they had been performed as specified for all (100%) of the 19 in the sample of 19 individuals. The corresponding analysis of the timely signature of these also indicated a 100 percent completion rate. The corresponding rates for the Reglan sample indicated that five of the six (83%) individuals had the DISCUS performed every three months. The record with missing documentation was for Individual #308, for whom only one DISCUS could be located, which was dated 5/22/13. The combined rate for the completion of the DISCUS, including both samples, would be 24 of 25 (96%). These uniformly high rates of completion indicated the Facility had developed and maintained a system to routinely ensure side effect monitoring tools were completed, as specified in the Settlement Agreement. This resulted in the finding that the Facility remained in substantial compliance with 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	This provision of the Settlement Agreement addresses processes 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." For the sample of 19 individuals, a description of the specific symptoms supporting the psychiatric diagnosis(es) of record could be identified for all (100%) of the individuals. At the time of the Monitoring Team's initial 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 the Monitoring Team's more recent reviews, this documentation could be located in the following four sections in the record: 1) the newly formatted CPAs; 2) the Quarterly Psychiatric Clinic review forms; 3) the "Psychiatric Consultation – Diagnostic and Treatment Analysis;" and 4) the Psychoactive Medication Treatment Plan. Psychiatric diagnoses 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	Substantial Compliance

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	the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	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 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 between those behaviors 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 percent of the sample of individual records that were reviewed. There were, of course, a number of individuals for whom it was determined that the behavior was derived from both psychiatric/biological factors and behavior/environmental contingencies. In these situations the relevant documentation would describe the mechanism, which accounted for this dual derivation. This usually related to individuals who had a biological condition such as a Bipolar Disorder, which could be exacerbated by environmental factors or an individual whose primary problem derived from a Pervasive Developmental Disorder, which 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. In all of the 19 (100%) records reviewed, empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. The Quarterly Review Forms carried forward six months of behavioral data 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 would, thus, allow one to visually ascertain the trends in the data over a one-year period of time. The behavioral data monitored was specific to the individual and included the overt behavioral 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 percent of the individual records reviewed. The Behavioral Data was actually collected and maintained by members of the Psychology staff and first appeared in the PBSP data and then was transferred to the	

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		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, and then were documented in the PBSP and the psychiatric documentation referenced above. The behavioral data section of the Quarterly Psychiatric Reviews would include a discussion of the timelines when positive effects of newly prescribed medication could reasonably be expected to occur and would also indicate if that time had passed due to the length of administration. This was primarily accomplished with a specific column in the listing of 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, would be documented and then elaborated on in the narrative section of the document, which appeared later in the form. 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 during which the effects of that 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 also routinely was incorporated into the Quarterly Review document format so that it was uniformly present in 100 percent of the records reviewed. LBSSLC Psychiatry and Psychology Progress Notes routinely carried forward two years of objective behavioral data. This was extremely valuable and clinically useful historical information. The utility of this information 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" category to justify the necessity of the medications prescribed for these individuals. The Facility would benefit from the 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 all of the 19 (100%) individuals reviewed. Documentation was present to show the individuals had been directly observed in conjunction with the Quarterly Reviews for the entire sample of 19 (100%) individuals.	

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		The format for the Quarterly meetings, in general, followed the format of the corresponding form that documented the meeting 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 EKG. If the individual was receiving a medication, such as a mood stabilizer, that required periodic monitoring of blood levels, these would also be 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 they had recently seen the Neurologist. All of this information was available in the Quarterly Review documentation for the team members to review, and would be discussed according to its relevance to the individual's current status. The Psychology staff would review the behavioral data, with input from the direct support professionals who worked with the individual on a daily basis. Nursing would review the relevant medical and laboratory data. The Psychiatrist chaired the meeting and would provide insights on the current issues and guide the discussion as to whether any medication or programmatic changes might be beneficial. The QDDP was also always present and was an active participant in the meeting. On 7/9/13 and 7/11/13, a member of the Monitoring Team observed the Psychiatric Medication Review meetings. The individual meetings consisted of both a monthly and quarterly follow-up review. 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 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 to the Quarterly Review format, the individual would be seen in 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 formation of a modified review meeting, which would be held as soon as possible, usually within hours. These meetings were documented in either Psychiatric Consultation Notes or a Dictated Integrated Progress Note, as described below.	

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		A listing of the various documents produced for these various encounters were as follows: ▪ Revised Comprehensive Psychiatric Evaluation: Revised annually and the individual was 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 was usually not seen. This was a summary document that covered the following topics: o Medications with rationale; o Diagnosis/symptoms/target symptoms; o Derivation; o Risk of illness; and o Benefit of pharmacological therapy (including past history); and ▪ The Psychoactive Medication Treatment Plan provided a detailed description of the essential elements of the rationale for the current psychotropic medication utilization, including the risk versus benefit considerations. An outline of the specific contents of this document is contained in the discussion related to J.8. The Psychiatry Department had maintained the progress it had made with several of the requirements specified in this section of the Settlement Agreement. This related to the continued 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 behavior described in the Monitoring Team's previous reports. Thus, LBSSLC maintained its rating of substantial compliance with this provision as was found for the previous review.	
J14	Commencing within six months of the Effective Date hereof and with	The review of the Rights/Consents sections of the records for the sample of 19 individuals receiving psychotropic medication indicated that nine (47%) individuals had	Substantial Compliance

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	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.	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 (100%) of these individuals. 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 20 to 30 percent 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, followed by request for written consent. 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 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); ▪ Risk of medication side effects; ▪ Risk of illness; and ▪ Risk-versus-Benefit discussion. This process was followed for both an initial approval for a new psychotropic medication and/or annual consents that were done as part of the ISP process. The document itself was signed by the Psychiatrist that prepared the document, the members of the Human Rights Committee that reviewed it, and the guardian or Facility Director providing the consent. The order of the signatures reflected the chronological order of the process. At the time of the Monitoring Team's prior review, 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	

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		from the primary responsibility of obtaining the consents for psychotropic medications. The Psychiatry Department had developed a document entitled "Psychoactive Medication Treatment Plan." As the responsibility for securing the consent was transferred from the Psychology Department to the Psychiatry Department, this document was used to augment the existing forms of documentation described with regard to Section J.13. The other purpose of this document was to ensure that risk-versus-benefit considerations were coordinated with other treatment methods and available to the IDT at the time of the annual review. With regard to Section J.10 of the Settlement Agreement, the Risk-versus-Benefit Analysis contained in the Psychiatry section of the record was now detailed and informative. Previously, this material had not been incorporated into the ISP discussions and related documentation. As noted with regard to Section J.8 and Section J.9, the Psychiatry Department, working in conjunction with the IDTs, had effectively addressed this problem. As indicated above, the Facility had developed a comprehensive system to assess the relative risks as well as the clinical benefits related to the use of psychotropic medication. This information had been effectively integrated into both the individual's ISP, as well as the documents that were supplied to both the Human Rights Committee and the individual's guardian (or the Facility Director for those who did not have a guardian). In addition, consents were found in all of the 19 (100%) individual records in the review sample. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Based on the Monitoring Team's observation of the Neurology Clinic on 7/10/13, 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 residential nursing staff accompanied the individual to the Clinic, and an additional nurse assigned to the Clinic helped to coordinate the flow of the individual reviews. The 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	Substantial Compliance

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		in the Neurologist's Note. The consistency of this process was verified through a review of the Neurology sections of 13 records within the sample of 19 individuals who required and received neurological consultation within the last year. The review of records indicated that during this time period, one of the two Consulting Neurologists reviewed the following individuals: Individual #146, Individual #183, Individual #127, Individual #6, Individual #103, Individual #82, Individual #30, Individual #320, Individual #233, Individual #213, Individual #68, Individual #114, and Individual #8. The Neurology Consultation Note documented the attendance of the Psychiatrist in all (100%) 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 referenced the psychotropic medications. The summary describing the substance of the Neurology Consultations 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. The language of this provision specifically indicates only that the coordination of treatment between Psychiatry and Neurology is maintained for those individuals who were receiving anticonvulsant medication for the dual treatment of both a seizure disorder and a psychiatric disorder, such as a mood disorder. The Psychiatry Department identified only seven individuals for whom this criterion would be applicable. Those individuals (and the date of the most recent Neurology Consultation) were as follows: Individual #299 (6/26/13); Individual #45 (7/10/13); Individual #105 (1/19/13); Individual #143 (5/3/13); Individual #242 (4/24/13); Individual #33 (2/13/13); and Individual #5 (6/20/13). The Facility exceeded this specific requirement of the Settlement Agreement by attending the Neurology appointments for all of the individuals who were jointly followed by both the Psychiatry and Neurology Departments. In summary, the collaboration between the Neurology and Psychiatry Departments was observed in the Neurology Clinic during the Monitoring Team's 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 previously had been asked if the Facility had engaged in an empirical analysis to determine if there was enough neurological consultation time	

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		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 feedback from the Consulting Neurologist, as well as the other clinicians 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 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 was the Chief of the Neurology Department at the Texas Tech Health Center. The contract to provide neurological services at LBSSLC was with the Texas Tech Health Center and was 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 Monitoring Team's 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.	

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 three consecutive months, as provided, for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; o For Section K.5, Structural and Functional Assessment Report (SFA) and/or Structural and Functional Assessment Review (SFAR), as provided, for: Individual #46, Individual #70, Individual #36, Individual #77, Individual #127, Individual #82, Individual #306, Individual #284, Individual #103, Individual #73, Individual #242, Individual #202, Individual #197, and Individual #83; o For Section K.5 and K.6, Psychological Assessments, including the Inventory for Client and Agency Planning (ICAP) Evaluations, as available for: Individual #46, Individual #70, Individual #36, Individual #77, Individual #183, Individual #127, Individual #82, Individual #34, Individual #306, Individual #284, Individual #103, Individual #220, Individual #73, Individual #242, Individual #202, Individual #197, Individual #83, Individual #235, Individual #167, Individual #273, and Individual #114; o For Section K.7, Psychological Assessments (including 30-day Psychological Summary), as available for: Individual #121, Individual #197, Individual #173, Individual #46, Individual #67, Individual #71, Individual #81, and Individual #51; o For Section K.8, Counseling skill acquisition programs (SAPs), monthly progress notes, and session notes, as available for: Individual #34, Individual #131, Individual #125, Individual #121, and Individual #197; o For Section K.9, Positive Behavior Support Plans, as available for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; o For Section K.9, Behavior Support Peer Review Committee approval/review sheet, Informed Consent for a Positive Behavior Support Plan form, HRC Review of PBSP consent form, as provided for: Individual #197, Individual #36, Individual #34, Individual #70, Individual #23, and Individual #83; o For Section K.10, Monthly PBSP Progress Notes, for three consecutive months, as provided, for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; and, o For Section K.11, Positive Behavior Support Plans, as available for: Individual #197,

	Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; ▪ **Interviews and Meetings with the following**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 7/8/13 and 7/9/13; o Tracey Snow-Murphy, Director of Residential Services, Rodshadi Moore, Active Treatment Supervisor, and Marty Jones, Integrated Program Developer, on 7/9/13 and 7/10/13; o Jim Forbes, Director of Behavioral Services, Carolyn Milton, Assistant Director of Behavioral Services, and Bob Robbins, QA Program Compliance Monitor, on 7/10/13; o Tracey Snow Murphy, Director of Residential Services, and Marilyn Foster, QA Program Compliance Monitor, on 7/10/13; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 7/10/13; o Sandi Kennedy, QDDP Coordinator, Section F meeting, on 7/10/13; o Mary Ortiz, Director of Competency Training and Development, and Irma Curry, Senior Instructor, on 7/11/13; and o Tracey Snow-Murphy, Director of Residential Services as well as Marty Jones, Integrated Program Developer, Jennifer Sageser, Integrated Program Developer, Sylvia Rios, Integrated Program Developer, and Reagan Criswell, Integrated Program Developer on 7/11/13. ▪ **Observations Conducted**: o Observation of PBSP competency based training at Violet (523), on 7/9/13; o Observation at Behavior Support Committee (BSC) Peer Review Meeting, on 7/11/13; o Observation of PBSP Competency Integrity Check at Oak (518), on 7/11/13; o Observation of PBSP Competency Integrity Check at Tulip (52), on 7/11/13; o Desensitization Committee Meeting, on 7/11/12; o Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the afternoon and/or evening hours at the following sites: ▪ Birch (514), on 7/8/13; ▪ Fir (516), on 7/8/13; ▪ Oak (518), on 7/9/13 and 7/11/13; ▪ Willow (520), on 7/9/13; ▪ Rose (525), on 7/10/13; ▪ Iris (527), on 7/10/13 and 7/11/13; ▪ Zinnia (528), on 7/10/13; ▪ Aspen (513), on 7/11/13; ▪ Canna (521), on 7/11/13; ▪ Violet (523), on 7/11/13; and ▪ Tulip (526), on 7/11/13.

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, dated 6/20/13. 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 provided documentation as well as interviews with staff: o The monitoring/audit tools used by QA/QI and other Facility staff to conduct its self-assessment included those used for the PBSP, monthly progress note, and SFA. Discussions while onsite reflected an interest by the Facility in potentially using integrity checks completed through direct observation in the future. Discussion also indicated that the QA/QI data might be included in the self-assessment in the future. ▪ 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 substantial compliance with the following sub-sections of Section K.2, K.3, K.5, K.8, and K.11. This was inconsistent with the Monitoring Team's findings. That is, the Monitoring Team found the Facility in substantial compliance with sub-sections Section K.2, K.3, and K.11.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, progress continued to be observed by psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing as well in the current peer-based systems implemented to provide internal and external peer review of psychological services. Efforts at improving standardized data collection, including effective monitoring and review, was noted. In general, progress was noted with regard to the inclusion of current target and replacement behavior data, including IOA and integrity data, as well as meaningful summaries of current functioning and implementation for behavioral programming. However, although many of the monthly notes appeared adequate, many were inadequate. Review of documentation revealed that most individuals served at LBSSLC, as reported, had a psychological assessment completed or updated within the last 12 months. Continued improvement in the quality of functional assessments, likely due to the revised format and self-monitoring checklist, was also noted. However, many of these assessments continued to contain outdated results from standardized testing or appeared to inadequately address limitations of previous assessments.

	Progress was noted in the provision and standardization of counseling supports. However, continued efforts directed at ensuring the adequate provision of programs designed to promote generalization by direct support professionals as well as ensure adequate and consistent data collection and monitoring/review of these services are required. Continued progress was noted in the development of quality PBSPs. Efforts aimed at ensuring consistency with regard to adequate operational definitions for replacement behaviors and behavioral objectives for target and replacement behaviors as well as ensuring all PBSPs receive consent and approval prior to implementation are still required. Substantial progress was noted in ensuring that PBSPs were written so that direct support professionals could understand them effectively. In addition, improvement was noted with regard to the provision of competency-based training.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs 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 by psychologists pursuing Board Certified Behavior Analyst (BCBA) credentialing. At the time of the current visit, four staff within the Behavioral Services Department had obtained their BCBAs. That is, of the current 11 professionals (including the Director and Assistant Director, four (36%) were currently BCBAs. This reflected the recent certification of two additional professionals since the Monitoring Team's previous visit. Based on current verbal reports, the Director and Assistant Director continued to not carry caseloads. Consequently, nine of the 11 professionals in the Department currently developed PBSPs. According to data presented within the Section K action plan and summary documentation provided in the Section K Presentation Book, at the time of the current onsite visit, two psychologists had completed all coursework as well as supervision requirements, and had recently taken the BCBA certification exam and were awaiting their results. In addition, one psychologist had completed all of the required coursework and four psychologists were currently enrolled in the University of North Texas behavior analyst course sequence. In addition, according to summary documentation in the Section K action plan, five psychologists were currently receiving necessary supervision. In summary, at the time of the Monitoring Team's current onsite visit, it appeared that all non-certified psychologists were making progress toward BCBA certification. The Facility was rated as being in noncompliance with this provision because the professionals in the Behavioral Services Department were not yet demonstrably	Noncompliance

		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. Although progress had been made, currently, only four members of the 11 Behavioral Health Services Department were BCBAs. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to support psychologists in their successful completion of required academic coursework as well as continue to ensure required supervision according to the Behavior Analyst Certification Board (BACB) eligibility guidelines.	
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. 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.	Continued improvement was evident in the current peer-based systems implemented to provide internal and external peer review of psychological services. 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 initially 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. However, according to the recently developed local policy, "Positive Behavior Support Practices" dated 4/1/13 (R), only three BCBAs, the psychologist/BCBA presenting a PBSP (or referred case), and Psychology Assistants (when on duty and when the PBSP/referred case was on their caseload) were required to attend. In addition, all Psychologists/Behavior Analysts were required to attend at least once per month. As previously noted, BSC was and continued to be required to meet weekly, with the exception of major holidays.	Substantial Compliance

		In an effort to examine the current nature of the internal peer review system, provided BSC meeting minutes over the last six months (i.e., January 2013 to June 2013) were reviewed. This included a sample of meeting minutes across a 23-week period from 1/7/13 through 6/13/13. Based on this review, it appeared that the BSC met at least once each week (i.e., for 100% of potential weeks) across the 23-week period. Indeed, there were seven weeks where the BSC met more than once. In total, there were 31 meetings held during this time period. The Director and/or Assistant Director of Behavioral Services attended all (100%) of the meetings. Closer examination revealed that the Director, Assistant Director, and the two other BCBAs attended 77%, 48%, 77%, and 52% of the meetings, respectively. The estimated average (and range) attendance at meetings for current psychologists and psychology assistants was 62% (52% to 84%) and 27% of the meetings, respectively. Although not required by current policy, attendance by QA/QI staff, one or more speech language professionals (SLPs), and the Human Rights Officer was 74%, 71%, and 52% of meetings, respectively. 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. Indeed, once the new policy (week of April 8, 2013) went into effect, attendance by three or more BCBAs occurred in 10 (91%) of 11 potential meetings (the exception was the BSC meeting on 5/23/13 where only two BCBAs were in attendance). The internal peer review process continued to be supplemented by the utilization of an external peer review process as well. Faculty and students from Texas Tech University continued to provide consultation, participate in BSC, and conduct intensive projects aimed at improving behavior services (e.g., data collection, monitoring, and review). These external reviewers included a Doctoral-level Board Certified Behavior Analyst (BCBA-D), as well as graduate students studying Special Education and Applied Behavior Analysis. Based on BSC meeting minutes, it appeared that the BCBA-D and graduate student(s) participated in five (16%) and 17 (55%) of the BSC meetings between 1/7/13 and 6/10/13, respectively. In addition to participation within the BSC, external peer review also was obtained through the participation of external reviewers, including BCBAs, from other Texas SSLCs via phone conferences. Based on provided external peer review meeting minutes (between 11/9/12 and 6/21/13), it appeared that one external peer review meeting, involving psychologists and BCBAs from other SSLCs and State Office, was held each month over the past eight months. Closer examination of meeting minutes revealed that AUSSLC, ABSSLC, CCSLC, and the Discipline Coordinator from the State Office participated as external reviewers in eight (100%), seven (88%), four (50%), and five (63%) of these scheduled meetings, respectively. The Director or Assistant Director as well as the psychologist or behavior analyst responsible for presenting the identified	

		case attended each meeting. Documentation regarding the case review (e.g., SFA, SFAR, psychological assessments, and data) was provided to attendees. According to verbal report, the meeting included review of provided materials as well as active discussion, reflective of a collaborative problem-solving solving approach. Provided documentation evidenced summary of discussion and feedback, including specific recommendations. Overall, this external peer review process appeared comprehensive, informed, and ultimately potentially helpful. Provided documentation was adequate to evidence that sufficient external peer review was ongoing and likely to be maintained. Overall, the Facility continued to maintain an effective internal peer review process through the BSC as well as substantially improved access to qualified external supports to provide consistent peer review. Based on the findings presented above, the Monitoring Team currently found the Facility in substantial compliance with this provision 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.	Since the last review, efforts at improving standardized data collection, including effective monitoring and review, was noted. However, as described below, continued improvement in these areas was needed. As described in the Monitoring Team's previous reports, significant efforts had been made to improve the effectiveness of the Facility-wide standardized data collection system. This system included the use index cards that allowed staff to immediately record data on target and replacement behaviors. This work continued to be supported through the collaboration between the Facility and Texas Tech University faculty and graduate students. Provided documentation indicated that a collaborative project aimed at improving data collection (using data cards) was still underway. Provided data (from October 2012 through May 2013) showed inconsistent effectiveness of the project across programs. And, although many programs showed increasing trends in the use of data cards, compliance rates remained below 50% for most programs. It should be noted that compliance rates of completing and submitting data cards was likely under-estimated given the project's stringent inclusion criteria. The Monitoring Team continued to find this project promising and plans to examine the outcomes associated with its continued implementation at the Monitoring Team's next visit. A second collaborative project between the Facility and Texas Tech University targeted improving the quality of monthly PBSP progress notes. This project involved examining the effectiveness of training psychologists to utilize the PBSP Progress Note Review rubric developed to improve (and monitor) the quality of monthly PBSP progress notes. Provided documentation suggested that the use of this rubric as well as ongoing monthly performance feedback significantly improved the quality of submitted progress notes. That is, average items correct increased from 54% to 79% over a three-month period (January to March 2013). This projected appeared very helpful in improving monthly	Noncompliance

		notes during this time period as well as through carry-over effects as progress appeared to be maintained during subsequent months, as evidenced by the current review of sampled monthly notes (i.e., March to May 2013 notes as reviewed below). In an effort to more closely examine the nature of data collection, including standard procedures and methods 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. Based on the PBSP Master List (i.e., behavioral services tracking grid), dated 7/11/13, this sample of 14 individuals reflected 10% of total number (N=135) of active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from March, April, and May 2013, as available. Review of provided documentation indicated: ▪ Monthly PBSP Progress Notes were completed across the last three consecutive months for 13 (93%) individuals. The second page of the monthly notes for March and April were missing for Individual #46 and, consequently, limited the current review. ▪ At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 13 (93%) of the individuals sampled. No replacement behavior was identified, defined, or graphed for Individual #242. In addition, although both verbal aggression and physical aggression were defined on the monthly note for Individual #34, only a single data path labeled "aggression" was graphed. ▪ Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 11 (79%) of the individuals sampled. Exceptions included the monthly notes for Individual #73, Individual #46, and Individual #242 where replacement behaviors were not adequately identified and/or defined. ▪ Target and replacement behaviors were consistent across the PBSP and monthly PBSP progress notes for 11 (79%) of the individuals sampled. More specifically, inconsistencies were found between the PBSP and monthly PBSP progress notes for the target and/or replacement behaviors (as defined in the PBSP and graphed on the progress note) for Individual #46, Individual #242, and Individual #284. It should be noted that these inconsistencies might be due to the Monitoring Team's review of recently updated PBSPs compared to monthly progress notes (i.e., March to May 2013) that were not as current (e.g., 6/3/13 for Individual #242, 7/3/13 for Individual #46, and 7/11/13 for Individual #125). ▪ Reference to inter-observer agreement (IOA) was noted in one or more of the monthly notes for 12 (86%) individual, but IOA data was only presented in the monthly notes for 11 (79%) individuals. The exceptions included Individual #197, Individual #73, and Individual #284. ▪ Reference to treatment integrity (competency integrity checks) was noted in one	

		or more the monthly notes for 13 (93%) individuals. The exception was Individual #197. Actual integrity data was presented in the monthly notes for 12 (86%) individuals, with the exception of the monthly note for Individual #197 and Individual #284. ▪ Monthly notes contained timely target and/or replacement behavior data in 11 (79%) of the individuals sampled. The exceptions were the April note (i.e., including data through July 2013) for Individual #197, the March note (i.e., including data through April) for Individual #242, and the April note (i.e., repeated the March header and corresponding text) for Individual #306. ▪ Monthly notes appeared to be completed and reviewed in a timely fashion (within 30 days) for 11 (79%) of the individuals sampled. The exceptions were the March note (signed in May) and the April note (signed in July) for Individual #197, the March and April notes (completion date unknown) for Individual #306, and the March note (signed in July) for Individual #284. ▪ Overall, the clinical notes appeared to be descriptive, integrative and offered clinical insight (beyond the graphed data) in the monthly notes for 10 (71%) of the individuals. Exceptions included the unorganized, cryptic and seemingly copied narrative (perhaps from observation notes) for Individual #197 and Individual #73, as well as the March comments concurrent with April data for Individual #306, and missing evidence of adequate comments (missing page 2) for Individual #46. Review of the Monthly PBSP Progress Notes continued to evidence improvement compared to previously reviewed notes. That is, in general, monthly notes appeared to include current target and replacement behavior data, including IOA and integrity data, as well as meaningful summaries of current functioning as well as implication for behavioral programming. However, although improvement was generally evident, not all reports included adequate definitions of replacement behaviors, sufficient IOA data, and a number did not appear to include timely data or evidence timely review. Consequently, although most of the monthly notes appeared adequate, there were many that appeared inadequate. On a positive note, some of the sampled notes provided evidence that re-evaluation of assessments and interventions had occurred based on data collected on observed target behaviors. For example, based on comments on monthly PBSP notes, it appeared that strategies in the PBSP were revised based on collected data for Individual #248 and Individual #202. In addition, monthly notes evidenced details regarding re-training due to currently observed data trends (i.e., Individual #306) as well as outcomes based on previous training (i.e., better data collection following training for Individual #70). Lastly, improvement continued to be noted in the use of appropriate graphing conventions. Descriptions related to progress in the use of appropriate graphing conventions are provided in the discussion related to Section K.10 of the Settlement	

		Agreement. As presented above, the current review of monthly PBSP progress notes evidenced improvement in the inclusion of descriptions of IOA and treatment integrity, in some cases including actual data, in the majority of sampled notes reviewed. However, as also discussed, improvement was needed to ensure this data was available in all monthly notes. It should be noted that additional supplemental documentation the Facility provided evidenced improvement in the collection of IOA and integrity data since the Monitoring Team's last visit. Specific information regarding progress in ensuring reliability of data and treatment fidelity was provided with regard to Section K.10 of the Settlement Agreement. In an effort to determine if assessments or interventions were re-evaluated or revised if target behaviors had not improved or had substantially changed, the "Reason for Assessment" as well as "Reason for Revision/Update/New PBSP" sections were examined. The sample included the same selected individuals as described above. This review was an attempt to identify assessments or interventions that were revised due to the psychologist's or behavior analyst's review of behavioral data. Of the 14 PBSPs reviewed, two (14%) appeared to be revised due to changes observed in behavioral functioning (i.e., Individual #248 and Individual #202). Of the 14 SFA/SFARs reviewed, one (7%) appeared to be revised due to either no progress or regression. In some cases, it was unclear if revisions in assessments or interventions were based on data. For example, the reviewer noted that: "The long-term trend for pica attempts shows a slight increase…" and "…(Individual #127's) PBSP has been revised …" but documentation did not clearly indicate whether or not the continued pica behavior was the rationale. A similar situation was noted for Individual #183 where pica attempts were described as "… show(ing) a very slight upward trend over the review period," and the reason for the subsequently revised PBSP did not appear related to this increasingly troublesome issue. Overall, however, based on these two examples, it appeared that increasing emphasis was being placed on re-evaluation or revision of behavioral supports based on lack of effectiveness of behavior programming. The Monitoring Team's previous report noted that the Facility no longer developed and implemented Safety Plans for Crisis Intervention (SPCI). In place of SPCIs, IDTs facilitated the development and integration of Crisis Intervention Plans (CIP) within the ISP in the form of restraint ISP action plans. To examine the nature of data collection methods typically utilized to summarize, monitor, and review progress on the implementation of CIPs, an individual (Individual #46) with a CIP was sampled and recent Monthly PBSP progress notes (from the last three months) were reviewed. Based on the documentation provided, dated 6/7/13, this sample reflected 13% of the total (N=8) number of individuals with CIPs as well as 25% of individuals with CIPs completed in the last six months. Review of monthly notes indicated that data on restraint use	

		(frequency data) within the sampled monthly PBSP progress notes was evident for the individual sampled. That is, "restraints" was a legend on the graphs included. However, it should be noted that missing documentation (from the April 2013 note) as well as the manner in which the data was displayed made it difficult to effectively review past and current data, and will impair any effective and efficient analysis of future data on use of restraints (more detailed information regarding this example is discussed with regard to Section K.10 of the Settlement Agreement). Overall, the standard methodology for data collection, monitoring and review continued to reflect progress. However, room for improvement was still evident with regard to the Facility-wide data collection system as well as with the monthly PBSP monitoring. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure adequate operational definitions of replacement behaviors, the display of timely target and replacement behavioral data, the inclusion of both IOA and integrity data, and timely and meaningful clinical review of monthly behavior data.	
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 continued to be noted in the development and implementation of psychological assessments. As presented 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 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 21 individuals who had ISP meetings within the last six months was selected and their most recent psychological assessment, as provided, was reviewed. Given the current census of 211 individuals, this sample reflected approximately 10% of the total number of psychological assessments currently in place. Of the 21 individuals sampled, 21 (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 21 (100%) of those sampled had an ICAP completed within the last three years. Of the psychological assessments reviewed, 19 (90%) included results of previously completed standardized tests of intelligence. These tests included, for example, the use of the Wechsler, Slosson, TONI, and/or Leiter. The exceptions were the psychological assessments completed for Individual #77 and Individual #73. More specifically, no intelligence testing was included within the assessment for Individual #77, and only results from the Developmental Profile II were included for Individual #73. In addition, of the 21 psychological assessments reviewed, 16 (76%) contained results of completed standardized measures of adaptive behavior utilizing either the Vineland Adaptive	Noncompliance

		Behavior Scale or the American Association on Intellectual and Developmental Disabilities (AAMD) Adaptive Behavior Scales. The remaining psychological assessments included the use of the ICAP as the only measure of adaptive behavior. Overall, findings based on the current sample appeared consistent with findings from the Monitoring Team's previous reviews. That is, psychological assessments consistently contained sections targeting specific content areas across reports, including information on reason for referral, data from previous assessments, including general assessment procedures and findings, an individual's history, preferences and strengths, mood/affect, cognitive and adaptive functioning, review of behavioral functioning, as well as levels of functioning, diagnoses, and recommendations. The inclusion of behavioral data, however, had been eliminated from reports as no behavioral data was noted. As presented with regard to Section K.6 of the Settlement Agreement, a consistent finding was the limited number of individuals with recently completed (within the last five years) standardized tests of intelligence and scales of adaptive behavior. Based on assessment dates listed within "Psychological Assessments" tracking spreadsheet, dated 7/10/13, at the time of the Monitoring Team's current onsite 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 (as described above) reflected 100% correspondence between the dates listed on the tracking spreadsheet and "dates of review" recorded on the sampled assessments provided for review. As observed during the Monitoring Team's previous reviews, screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessments 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. In addition to the completion of traditional psychological assessments, functional behavioral assessments were also completed. As presented in the Monitoring Team's previous reports, these assessments were the primary method used to identify medical, psychiatric, environmental, and/or other reasons for target behavior. As previously described, individuals who received behavioral and/or psychopharmacological interventions were required to have this functional assessment completed in an effort to promote a better understanding of the nature of maladaptive responding and develop more effective and individualized behavioral interventions.	

		As noted in the previous Monitoring Team report, both the "Structural and Functional Assessment" and "Structural and Functional Assessment Review" were utilized by the Facility. The later format was developed to assist psychologists and behavior analysts in determining whether or not to revise the previously completed SFA. As noted in the Monitoring Team's earlier reports, use of this rubric offered the opportunity to consider the various factors that might necessitate a re-evaluation and subsequent completion of a more current SFA. Currently, according to the behavioral services tracking grid, dated 7/11/13, approximately 130 (96%) of individuals with PBSPs had an SFA or SFAR completed within one year of BSC approval of the PBSP. The exceptions, according to summary documentation, included five individuals (i.e., Individual #156, Individual #109, Individual #173, Individual #121, and Individual #315), two of whom were readmitted to the Facility in the last six months. In an effort to more closely examine the nature of current SFA or SFARs, 14 individuals with ISP meetings completed within the last six months and with PBSPs were selected. This sample of 14 individuals reflected 10% of the total number of individuals with PBSPs (N=135). Review of provided SFAs and SFARs indicated that an SFA and/or SFAR was/were completed within the last 12 months for 14 (100%) of those sampled. More specifically, of the 14 individuals selected, a current SFA (completed within the past 12 months) was provided for seven individuals (i.e., Individual #46, Individual #70, Individual #82, Individual #73, Individual #202, Individual #197, and Individual #83). Of those seven individuals without recently completed SFAs, it appeared that all seven (100%) had an SFAR completed in the last 12 months (i.e., Individual #36, Individual #77, Individual #127, Individual #306, Individual #284, Individual #103, and Individual #242). It appeared that Individual #70 had both an SFA and SFAR completed within the past 12 months. After closely examining sampled SFAs, it was apparent that more recently completed assessments (i.e., those completed in the last 12 months) utilized a more comprehensive and structured format that promoted the conspicuous inclusion of necessary elements. Indeed, the Monitoring Team observed that the most recent format was a significant improvement over the older format. More specifically, the older assessments typically did not conspicuously highlight all of the critical elements. The current review of the sampled SFAs revealed that 100% of the SFAs completed within the last year contained all of the necessary elements, with the exception of signatures and signature dates. More specifically, only four (57%) of the seven signatures recorded on sampled SFAs were dated. The exceptions were Individual #82, Individual #73, and Individual #197. Of the SFAs completed more than one year ago (i.e., Individual #36, Individual #77, Individual #127, Individual #284, Individual #103, Individual #242, and Individual #306), almost all evidenced missing content in the areas of rationale for completion (reason for review), derivation, response to PBSP, and	

		description of any necessary accommodations. Of these, two were also missing recommendations (Individual #8 and Individual #306). Overall, current findings indicated that older SFAs were missing critical elements. This result was not surprising, given the Facility had made significant efforts to improve the quality of assessments as evidenced by noted progress in recently completed SFAs. After closely examining sampled SFARs, it was apparent that this format continued to provide an efficient structure in which to review previously completed SFAs. For example, this format asked reviewers to examine how the previous SFA identified and defined target behaviors, addressed the derivation of behaviors of concern, conceptualized the relevant contingencies as well as examined the response to the current PBSP (included review of IOA and integrity data), considered other important factors previously not addressed, and determined the adequacy of the previous SFA (using the Structural and Functional Assessment Self-Monitoring Checklist). Indeed, the utilization of this format would allow assessors to identify any relevant changes (or no changes) over time, including the efficacy of behavioral interventions, as well as address any limitations noted within previous SFAs. Overall, the Monitoring Team found the format of the SFAR to be potentially very helpful when reviewing the quality and current relevance of previously completed SFAs. The current review of SFARs evidenced specific concerns within some of the sampled assessments. That is, many of the SFARs reviewed did not appear to sufficiently address issues related to inter-observer agreement and treatment integrity as specifically referenced in question #4 on the SFAR. Question #4 asked the reviewer, in part, to "… take into consideration treatment integrity and reliability of the data." Of the eight reviewed, only four (50%) and five (63%) SFARs contained any content reflecting consideration of or reference to IOA (i.e., exceptions included Individual #70, Individual #127, Individual #103, and Individual #242) and treatment integrity (i.e., exceptions included Individual #127, Individual #103, and Individual #242), respectively. Although actual data might not have been required, IOA or treatment integrity data was not reported in any of the sampled SFARs. When content reflecting IOA or treatment integrity was found, it was in some cases vague and unclear, leading the Monitoring Team to question whether or not the reviewers clearly understood the concepts of IOA and treatment integrity and how these measures were formally completed. Indeed, the descriptions often did not appear to match the Facility's currently established methods of examining IOA and treatment integrity. For example, the SFAR for Individual #77 indicated that: "The rate of documented challenging behaviors, in comparison to direct observations and informal interviews with staff, indicate sufficient integrity and reliability of data." Based on this statement, it was unclear to the Monitoring Team if actual IOA probes and/or integrity checks were completed as the Facility had prescribed. The current review of sampled documentation also noted that, although all of the SFARs	

		mentioned the use of the Structural and Functional Assessment Self-Monitoring Checklist (i.e., as referenced in Question #6 on the SFAR), most descriptions did not appear to reflect its complete and/or accurate utilization. More specifically, although older SFAs (i.e., completed over 12 months ago) did not typically include content targeting "reason for assessment," "response to PBSP," "derivation," and/or "accommodations," only two (25%) of the eight sampled SFARs discussed inadequacies within two or more of these areas (i.e., Individual #127 and Individual #103) specifically within the answer to Question #6. Indeed, only the response (i.e., to Question #6) on the SFAR for Individual #127 appeared to specifically identify more than two areas of inadequacy within the older assessments, thus providing evidence where the checklist was used completely and as intended. Consequently, when answering Question #6 on the SFAR, psychologists who specify the shortcomings of earlier SFAs will highlight the utility of this abbreviated format. Overall, of the sampled SFARs, most appeared to effectively supplement previously completed SFAs. It should be noted, however, that several of the SFARs were missing content when compared with similar recently completed documents, including inadequate identification and definition of target behaviors (Individual #284 and Individual #77), missing recommendations (Individual #284 and Individual #77) and determination (Individual #306) sections, and several were not dated (Individual #127 and Individual #103). Overall, it appeared that continued improvement in the quality of functional assessments was likely due to the revised SFA format as well as use of the Structural and Functional Assessment Self-Monitoring Checklist and SFAR, when completed fully and accurately. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure the adequate completion of SFARs, including the adequate completion of the self-monitoring checklist when reviewing previously completed SFAs.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	As described in the Monitoring Team's previous reports, the Facility's expectation that each individual residing at LBSSLC have a current psychological evaluation had remained unchanged. This required that a psychological assessment be completed, updated, and/or reviewed at least annually for each individual served. This expectation included reviewing results from the Inventory for Client and Agency Planning evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years, or sooner, if significant events appeared to impact adaptive functioning. To determine whether or not psychological assessments were based on current, accurate, and complete clinical and behavioral data, psychological assessments and ICAP documentation, as available, from a sample of 21 individuals was examined. This sample was selected from those individuals that had had an ISP meeting within the past six months. Given the current census of 211 individuals at the time of the current visit, this sample reflected approximately 10% of the total number of psychological assessments.	Noncompliance

		As previously presented with regard to Section K.5 of the Settlement Agreement, of the sampled assessments reviewed, 21 (100%) were updated within the last 12 months. It should be noted, however, that, in some cases, it remained unclear to the Monitoring Team which date represented the final completion of the assessment. That is, some plans contained multiple dates, including one or more signature dates, as well as a date in the footer of the document, which often did not match the "Date of Report." Indeed, of the 21 assessments sampled, 13 (62%) had two or more dates recorded and five (24%) had three or more dates recorded. Consequently, it was challenging for the Monitoring Team to determine when the assessment was considered complete. This determination was necessary to examine whether or not the assessment was completed prior to the ISP meeting. Currently, when comparing the recorded "Date of Report" date (as listed on the front of the document) with the ISP meeting date, it appeared that 21 (100%) of the assessments were completed prior to the ISP. However, when comparing the signature dates or the date found within the footer, only 14 (67%) appeared to be completed prior to the ISP meeting. The exceptions were the assessments for Individual #46, Individual #36, Individual #77, Individual #127, Individual #284, Individual #202, and Individual #83. Overall, although 100% of the sampled psychological assessments were updated within the last 12 months, it was unclear how many of the sampled psychological assessments were fully completed prior to the ISP meeting. Provided documentation indicated that, of the psychological assessments reviewed, 21 (100%) of the sampled individuals had an ICAP evaluation completed within the last three years. In addition, 19 (90%) of the 21 contained results of previously completed standardized tests of intelligence. Standardized tests of intelligence included the use of the Wechsler, Slosson, Toni, and/or Leiter tests. Exceptions included assessments where testing results were not reported (Individual #77) or where testing results did not reflect typical standardized intellectual assessment (i.e., the assessment for Individual #73 only reported results of a developmental profile). Of the 19 assessments with scores, only nine (47%) reported findings based on intellectual testing completed within the last five years. The exceptions included psychological assessments for 10 individuals that contained testing results that were over ten year old (i.e., Individual #183, Individual #127, Individual #82, Individual #306, Individual #284, Individual #103, Individual #242, Individual #167, Individual #273, and Individual #114). Of the 21 sampled psychological assessments, tests of adaptive functioning (i.e., Vineland Adaptive Behavior Scales) were reported in 16 (76%) of the sampled assessments. The exceptions included the assessments of Individual #46, Individual #36, Individual #127, Individual #82, and Individual #114 where results of adaptive behavior scales, other than the ICAP, were not reported. Of these 16 assessments, only eight (50%) reported tests of adaptive behavior scales (other than the ICAP) completed within the past five years. The exceptions, including assessments reporting scales completed over five years	

		ago (Individual #83) as well as those completed over 10 years ago (Individual #77, Individual #306, Individual #284, Individual #103, Individual #73, Individual #242, and Individual #273). The Monitoring Team's previous reports noted improvements in updating intelligence testing and completion of adaptive behavior scales over the course of the last few visits. More specifically, since the previous reviews, standardized tests of intelligence and/or adaptive behavior scales were recently completed for 11 and 22 individuals as noted within the Monitoring Team's March 2012 and October 2012 reports, respectively. Currently, according to the Record of New Psychological Testing (dated 7/10/13), it appeared that this progress continued as new testing, including intellectual functioning and/or adaptive behavior, was completed for 35 individuals since the Monitoring Team's last visit (i.e., between October 2012 and July 2013). Provided summary data indicated that, as of 6/24/13, 63 (29.5%) current residents had psychological testing completed within the past five years. Although this progress was positive, it should be noted that no new testing had been completed since February 2013. That is, provided documentation (i.e., testing dates) as well as verbal reports from the Director of Behavioral Services indicated that new testing was "put on hold" based on directives from State Office. It was reported that the Facility was awaiting the pending State-level policy that would include new guidelines for the completion of annual psychological assessments. Overall, recently completed (i.e., within the last five years) standardized tests of intelligence and/or tests of adaptive functioning (e.g., Vineland Adaptive Behavior Scales) were found in eight (38%) of the 21 sampled psychological assessments. Interestingly, although recently completed testing results appeared available for individuals within the current sample, descriptions of these results, as consistent with the format and content found in psychological assessments of other individuals (e.g., Individual #183, Individual #127, and Individual #70), were not evident within current assessments for several of the individuals sampled. More specifically, recent results from standardized intelligence tests and/or adaptive scales were not similarly described for Individual #197, Individual #34, Individual #220, and Individual #46 even though this information was reportedly recently obtained. Indeed, this limited description of findings from recent testing was conspicuous given the presence of data provided from recently completed ICAPs (e.g., Individual #46, Individual #220, Individual #70, and Individual #34). It was unclear to the Monitoring Team why the results of recently completed ICAPs would be much more comprehensive and sufficiently detailed in current assessments and a similar level of detail regarding intellectual and/or adaptive behavior testing would not be included. Overall, the Monitoring Team found it unfortunate that the Facility's continued progress in updating standardized tests of intelligence and adaptive behavior was recently "placed on hold." Consequently, a substantial number of assessments remained outdated. In	

		addition, it appeared that recent results from current testing might have been available but not adequately described in current psychological assessments. Lastly, the Monitoring Team could not confirm how many of the sampled assessments were actually completed prior to ISP. Given these findings, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility reinitiate efforts at updating standardized tests of intelligence and adaptive behavior scales, ensure that psychological assessments are completed prior to the ISP, and that relevant findings from recent testing are adequately described or summarized in an effort to maximize the potential treatment utility of psychological assessments.	
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, 20 (95%) had a psychological assessment that was updated within the last 12 months. Documentation also indicated that 21 (100%) of those sampled had an ICAP completed within the last three years. In addition, 19 (90%) included results of previously completed standardized tests of intelligence. Of these, nine (47%) were completed within the last five years. In addition, of the psychological assessments reviewed, 16 (76%) included results of previously completed standardized tests of adaptive behavior (not including the ICAP). Of these, eight (50%) were completed within the last five years. As presented with regard to Section K.5 of the Settlement Agreement, based on dates listed within "Psychological Assessments" tracking spreadsheet, dated 7/10/13, 100% of the psychological assessments had been updated within the past 12 months. 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 95% correspondence between the dates listed and the sampled documents provided for review. The exception was the psychological assessment (dated 5/14/12) for Individual #114 that appeared outdated and potentially replaced by a more recent, but currently unavailable, psychological assessment. As previously reported, LBSSLC policy required that a psychological assessment be completed one month from the date of an individual's admittance. According to provided documentation (LB-1307-I.17), nine individuals were admitted to the Facility since the Monitoring Team's previous visit. These admissions included Individual #121, Individual #197, Individual #173, Individual #46, Individual #64, Individual #67, Individual #71, Individual #81, and Individual #51. Documentation indicated that three of these individuals had been returned to the Facility from the community (Individual #121, Individual #197, and Individual #173) and that one individual has been admitted and then quickly transitioned into the community (Individual #64). Of these nine admissions, however, adequate documentation for only seven individuals was provided to the Monitoring Team for review. The exceptions were Individual #197 and Individual	Noncompliance

		#64. It should be noted that provided summary documentation (in Section K.7 of the Presentation Book) indicated that a psychological assessment was completed for Individual #64. However, the Facility chose not to include this assessment along with other provided documentation given that he was no longer a resident of LBSSLC. Based on this rationale, Individual #64 was not included within the current sample of reviewed documentation (as described below). It was unclear to the Monitoring Team why summary documentation (as described above) did not include any information on the psychological assessments completed for Individual #197. Indeed, this individual was similar to other individuals (Individual #121 and Individual #173) listed within summary documentation who had been re-admitted to the Facility following a community placement and whose psychological assessments were provided. It should be noted, however, that a "Furlough Summary" (dated 9/4/12) was provided for Individual #197. This appeared to be an updated psychological assessment completed in preparation for her move into the community and not following her recent re-admission (on 2/7/13) to the Facility. Although evidence of the completion of a psychological assessment following her re-admission to the Facility was not provided, Individual #197 was included in the current sample (described below). The Monitoring Team based this decision on the fact that the Facility appeared to adhere to the LBSSLC policy (i.e., requiring a psychological assessment be completed one month from the date of an individual's admittance) for other individuals (i.e., Individual #121 and Individual #173) who were similarly re-admitted to the Facility following community placements. Based on provided psychological assessment documentation, of the eight sampled individuals recently admitted, seven (88%) had "30 Day Psychological Summary" completed within 30 days of admission. The exception was Individual #197 (no evidence was available). It should be noted, however, that this finding was based on comparison of the admission date with the "Date of Report" (as listed on the 1st page) on the psychological summary for each individual. Closer examination of the signature dates of the author and peer reviewer for Individual #51 revealed that the assessment was likely completed more than two months after admission. Consequently, available evidence suggested that, of the eight individuals sampled, only six (75%) evidenced psychological assessments completed within 30 days of admission. Available documentation also indicated that, of the eight sampled individuals recently admitted, seven (88%) had an ICAP completed within the last three years and seven (88%) had results of previously completed standardized tests of intelligence. Of these seven, two (29%) individuals had tests completed within the last five years. That is, standardized intelligence tests were completed for Individual #46 and Individual #67 within one month of admission. In addition, three (38%) of the eight sampled individuals had results of previously completed standardized tests of adaptive behavior (not including the ICAP). Of these, zero (0%) individuals had adaptive testing completed within the last five years.	

		Overall, documentation revealed that most sampled individuals, as well as all of the individuals served at LBSSLC, as reported, had a psychological assessment completed or updated within the last 12 months. However, many of these assessments contained outdated tests of intelligence and adaptive behavior. In addition, the Facility did not adequately complete psychological assessments within one month of admission for individuals admitted since the Monitoring Team's last visit. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility complete more updated standardized intelligence tests and adaptive behavior scales as well as ensure adequate and timely completion of psychological assessment for all admissions to the Facility.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Progress was noted in the provision and monitoring of psychological services other than PBSPs, including counseling supports. The Monitoring Team's previous report noted the development of a standardized format for counseling treatment plans as well as a systematic method (i.e., data tracking sheets) for monitoring and graphing progress of performance on counseling targets. It was reported that the Facility worked closely with community-based therapists to facilitate adequate counseling treatment plans, weekly session notes, and monthly summaries. Currently, based on verbal report and provided documentation, dated 6/7/13, it appeared that three community-based counselors provided counseling services to five individuals. To more closely examine the nature of these psychological services and supports, counseling treatment plans (i.e., "Counseling Skill Acquisition Program") as well as monthly counseling progress notes and weekly session notes, for the last three months, as available, were reviewed for three individuals currently receiving counseling supports. It should be noted that this sample was selected based on its availability as provided through the Monitoring Team's pre-visit documentation request (Section K-VIII.14). Based on provided summary documentation, this sample represented 60% of those individuals (N=5) currently receiving counseling services. Of the three individuals, the following was found: ▪ Three (100%) had a counseling skill acquisition program. Although, it was unknown when the programs were developed and/or implemented as none of the programs were dated; ▪ Three (100%) had a counseling skill acquisition program in which one or more treatment objectives were identified. However, none (0%) of the objectives appeared adequate. More details are provided below; ▪ Three (100%) had a counseling skill acquisition program in which one or more counseling session targeted behaviors were identified and operationally defined. However, only the operational definitions included in one (33%) of the three skill acquisition programs appeared sufficient. More details are provided below;	Noncompliance

		▪ Three (100%) had a counseling skill acquisition program that included a description of the treatment methodology; ▪ Three (100%) had a counseling skill acquisition program that identified generalization and maintenance procedures. However, none (0%) of these sections were found to provide sufficient detail. More details are discussed below; ▪ Three (100%) had a counseling skill acquisition program that conspicuously identified a therapist, setting, and schedule (including session length) for counseling sessions; ▪ Three (100%) had a counseling skill acquisition program that specified data collection procedures. However, none (0%) of the procedures appeared adequately followed (based on provided documentation). More details are provided below; ▪ Three (100%) had weekly sessions notes completed for most weeks counseling sessions were completed (over the three month period requested). However, concerns were noted and discussed below; and ▪ Three (100%) had monthly progress notes completed for all months where counseling sessions were completed (over the three-month period requested). However, concerns were noted and discussed below. Overall, it appeared that the counseling skill acquisition programs, weekly session notes, and monthly counseling progress notes were standardized across all individuals sampled. As previously reported, this structured format appeared likely to facilitate a more consistent and higher quality document (i.e., containing necessary elements). However, concerns were noted with regard to several sections within sampled documents. More specifically, treatment objectives were written to capture multiple forms of responding, making it difficult to accurately measure changes in responding over time. For example, one of the treatment objectives for Individual #197 indicated that "… [Individual] will independently identify at least one challenge or success regarding appropriate communication…" Given how this was written, it appeared theoretically possible (but perhaps unlikely) for the individual to meet the goal by identifying only unresolved problems (i.e., "challenge") and never any positive outcomes (i.e., the intent of the counseling sessions). Similarly, one of the objectives for Individual #125 indicated that "… [Individual] will independently identify at least one good choice or bad choice per session…" Again, this was phrased in a way that would allow obtainment of the objective through the identification of primarily maladaptive responding, which appeared to be opposed to the intent of the skill program. In addition, one of the treatment objectives for Individual #34 indicated that "… [Individual] will independently identify at least one challenge or success regarding self-injurious behavior, physical aggression, verbal aggression, suicidal behavior, pica, and functioning communication per session…" Given how this was written, it appeared that the individual would need to identify at least six challenges or success in order to meet the	

		objective per session. If this was accurate, the current data collection system appeared insufficient. The operational definitions of marker behaviors or counseling session targeted behaviors for Individual #34 and Individual #197 were rather vague. As noted in the Monitoring Team's previous reports, although these definitions might be intentionally broad by design, it seemed potentially problematic for other staff (i.e., psychologists, and direct support professionals) to accurately identify and reliably monitor identified responses as these strategies were integrated (generalized) into home and work settings. The addition of examples for each marker behavior, especially "solution" and "prevention," might increase the likelihood that non-clinical staff could prompt and/or recognize these planned responses. In addition, the definitions of these terms reflected primarily verbal behavior. That is, definitions targeted what the individual verbally "agrees" to do and not what the individual actually does. Although improving verbal responding as a counseling target(s) was a valid and meaningful objective, identifying additional non-verbal replacement responses (e.g., actually leaving an area when upset) would offer a more comprehensive way to monitor behavior change. Supplemental counseling marker behaviors targeting overt responses, for example, would allow the Facility to more closely monitor the correspondence between target behaviors, replacement behaviors and/or counseling session target behaviors. This appeared to be the approach reflected in the counseling skill acquisition program for Individual #125. Lastly, the usefulness of the last targeted counseling session behavior, a verbal response entitled "maintenance action" (i.e., defined as agreement to continue solutions and preventions), beyond that evidenced through the display of "solution" or "prevention," was unclear to the Monitoring Team. The generalization and maintenance sections in the counseling skill acquisition programs for Individual #34, Individual #125, and Individual #197 provided a reference to a skill acquisition program to be implemented at home by direct support professionals. These programs, referred to as generalization skill acquisition program, appeared to be recently developed. More specifically, examples of these generalized skill programs were provided within the Section K Presentation Book, but additional documentation including evidence of their current use as SAPs (i.e., their inclusion with other SAPs, monthly data sheets, and monthly summaries) was not provided. For example, the program included with the provided SAPs for Individual #34 was the plan designed "For counseling sessions with Licensed Professional Counselor" and included the data sheet (and data) designed for the counseling sessions. That is, completed data sheets (and data) reflecting the prescribed documentation (i.e., "document on the progress note 3 times weekly as assigned by the RC" as stated on the SAP designed for home implementation) was not provided for review. More details related to these specific issues and the overall quality of these programs are provided with regard to Section S.2 of the Settlement Agreement.	

		The counseling skill acquisition programs prescribed the collection of weekly session notes from counselors by psychologists/behavior analysts who then were required to complete weekly graphed progress notes on a monthly basis. This included, according to the programs, the monthly graphing of weekly target behavior frequencies. Although monthly progress notes appeared to be completed, weekly data was not graphed. In addition, the frequency of target behaviors was inconsistently recorded within the summarized format. More specifically, data on monthly progress notes reflected prompt levels required to occasion responding per session, but did not typically reflect an actual frequency (count) of targeted behaviors. Indeed, it appeared that the collection of actual frequency data was variable across sessions and was not always summarized or displayed in the monthly progress notes. In addition, review of the correspondence between actual session notes and the relevant monthly counseling note revealed errors in transcription (e.g., monthly note for Individual #197), missing target behaviors, including "challenge" and "success," on data sheets as well as missing recorded prompt levels (e.g., April monthly note for #34). According to the revised Positive Behavior Support Practices policy, dated 4/1/13, the completion of monthly progress notes for counseling and generalization skill acquisition programs were required. As noted above, data from the implementation of these generalized skill acquisition programs was not currently provided for review. 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 evidenced-based. As indicated within Monitoring Team's reports, in addition to the counseling services, other types of therapeutic services (e.g., sensory diet, body sock, sensory room) had been previously noted. Consequently, recommendations to the Facility included ensuring that all psychological supports and services adhered to rigorous, evidenced-based standards. In response, the Facility worked to transition away from using non-evidenced based approaches. For example, according to provided documentation, the Facility recently had revised the Positive Behavior Support Practices policy (dated 4/1/13) to clarify that psychological and behavioral therapies included evidenced-based practices and not strategies such as sensory diets, sensory rooms, sensory integration, and aromatherapy. The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to improve the quality of counseling treatment plans, including programs designed for implementation by counselors and direct support professionals, as well as ensure adequate and consistent data collection (across the counseling office and residential settings), and monitoring/review of these services.	
K9	By six weeks from the date of the	Continued progress was noted in the development of quality PBSPs.	Noncompliance

	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.	As noted in the Monitoring Team's previous report, a newly revised PBSP format had been developed. At that time, the new format appeared much more concise and user-friendly than previous reviewed formats. Current observation noted that this format had been revised since the Monitoring Team's last visit to include additional information (this is described below). It an attempt to examine the current status of active PBSPs, a sample of 14 individuals who had ISPs within the last six months and who also had PBSPs was selected. The PBSP as well as provided SFAs and/or SFARs were examined. Based on the PBSP Master List, dated 7/11/13, this sample of 14 individuals reflected 10% of total number (N=135) of individuals with active PBSPs. Of the 14 individuals sampled, 14 (100%) had PBSPs completed using the most recent PBSP format. It was noted, however, that the current format was a bit longer. That is, the length of the document was approximately one page longer (on average). Based on review of the PBSP, of the 14 individuals, the following was found: ▪ 14 (100%) were based on a completed SFA and, in some cases, a more recent SFAR; ▪ 14 (100%) included a rationale for development or revision of the PBSP. This included one PBSP that appeared updated due to limited progress in response to the PBSP (as noted in the SFAR for Individual #306); ▪ 14 (100%) included operational definitions of target behaviors; ▪ 13 included operational definitions of replacement behaviors. However, of these, three included inadequate definitions for one or more replacement behaviors (i.e., Individual #73, Individual #220, and Individual #36). The PBSP for Individual #242 did not have any replacement behavior identified or defined. As a result, only ten (71%) included adequate operational definitions for replacement behaviors; ▪ 14 (100%) included a purpose(s) of the plan, including proposed underlying function(s) of target behaviors; ▪ 14 included behavioral objectives for target behaviors. However, of these, two included incomplete objectives for one or more target behaviors (i.e., Individual #73 and Individual #284). As a result, only 12 (86%) included adequate behavioral objectives for target behaviors; ▪ 12 (86%) included behavioral objectives for replacement behaviors. The exceptions were PBSPs for Individual #127 and Individual #242. It should be noted that the Monitoring Team recognized that the SFA and Psychological Assessment for Individual #242 emphasized that her challenging behaviors appeared to result primarily from an underlying psychiatric disorder and, subsequently, that the identification of and strategies targeting functionally equivalent replacement behaviors appeared inappropriate. In these cases, the Facility is encouraged to consider teaching adaptive or alternative behaviors that, although not a true functional equivalent, may nonetheless ameliorate symptoms or outcomes associated with underlying condition. For example, the	

		PBSP for Individual #242 identified several marker behaviors (i.e., agitated behavior and manic episodes) as indicators of medication effectiveness, but no other alternative response(s) were identified. In this case, the PSBP could identify, define, and track "participation in an activity" (as currently prescribed in the PBSP under Interventions) or attempt to teach a more incompatible response (to lessen the likelihood of pulling out her feeding tube). These considerations appear consistent with the LBSSLC Positive Behavior Support Plan policy (dated 4/1/13R), which indicated that SFAs and PSBPs may propose replacement or alternative behaviors for skill acquisition; ▪ 13 (93%) included baseline data. The exception was Individual #306; ▪ Six (43%) conspicuously identified the use of SAPs to formally address the acquisition of replacement or alternative behaviors. The exceptions were Individual #46, Individual #34, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; ▪ 14 (100%) included antecedent-based or preventative strategies; ▪ 14 included strategies to promote replacement or alternative behavior. However, the procedure described in three of the plans appeared inadequate or insufficient to promote change in maladaptive responding (i.e., Individual #242, Individual #183, and Individual #70). Consequently, only 11 (79%) of the PBSPs appeared to provide (or reference) adequate programming to promote the acquisition of replacement or alternative behavior; ▪ 14 (100%) included consequence-based strategies or interventions aimed at weakening target behaviors: ▪ 14 appeared to include the use of positive reinforcement. However, the prescribed use of potentially robust individualized reinforcers were only conspicuously evident in 11 (79%) of the PBSPs (the exception were the PBSPs for Individual #242, Individual #183 and Individual #70); ▪ 14 (100%) included descriptions of data collection procedures; ▪ 13 (93%) included descriptions of plans to reduce the intensity of intervention(s). The exception was Individual #36, where this information was incomplete; ▪ 14 (100%) included grade level readability estimates all below a 7.0 grade level; ▪ 14 (100%) included the formatting and directions for conducting competency-integrity checks; and ▪ 13 (93%) were signed and dated. The exception was the PBSP for Individual #183. Overall, consistent with findings from the previous Monitoring Team report, the revised PBSP format continued to facilitate plans that were similarly structured, included consistent content and remained relatively concise and user-friendly. In general, definitions remained 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 typically presented in order and included the use of positive reinforcement (i.e., in many cases using individually identified reinforcers). However, similar to previous reports, several areas of concern remained. For example, in several cases, the operational definitions for replacement behaviors remained problematic and related behavioral objectives were either missing, unclear or inadequate. In addition, it was not always evident in PBSPs if SAPs were developed to provide supplemental structure in the acquisition of replacement or alternative behaviors. Indeed, in several PBSPs, strategies targeting the acquisition of more adaptive responses, including the use of individualized reinforcers, appeared non-specific and likely inadequate. Lastly, there was some variability noted with the amount of content in PBSPs specifically describing medical and/or psychiatric issues as well as descriptions related to the effectiveness of past or current interventions. For example, descriptions of previous interventions and their effectiveness were only evident within the PBSPs, SFA, and/or SFAR for seven (50%) of the individuals sampled. More specifically, previous interventions as well as their effectiveness were not conspicuously evident in the reviewed documentation for Individual 197, Individual #127, Individual #220, Individual #36, Individual #34, Individual #242, and Individual #183. However, issues related to intervention efficacy appeared to be more comprehensively addressed in more recent SFAs that utilized the new format including an item specifically prompting a response(s) related to the effectiveness of past strategies (e.g., Individual #73, Individual #46, Individual #306, and Individual #202). This information, although relevant, could meaningfully be described more fully in the SFA or SFAR without necessary inclusion within the PBSP. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the PBSP as well as to determine if plans were implemented in a timely manner once consent was obtained, the date of consent, date of approval, and implementation date of PBSPs on the "PBSP Master List" (tracking spreadsheet), dated 7/11/13, were examined. Six individuals who had an ISP meeting within the last six months and who also had PBSP were selected for the current sample. Based on the PBSP Master List, this sample of six individuals reflected 4% of total number (N=135) of active PBSPs. The BSC approval date, HRC approval date, date of consent of the guardian (or Facility Director), and the implementation date of the PBSP was examined for each individual sampled. According to the dates provided, necessary consents were obtained prior to the implementation of the PBSP for approximately five (83%) of those individuals sampled. More specifically, according to provided documentation it appeared that the PBSP for Individual #83 was implemented (on 3/11/13) prior to BSC or the Director's approval. In addition, of those sampled, six (100%) PBSPs were implemented within 14 days of receiving necessary consent from the guardian or approval from the Director. Overall, based on the current tracking grid, 131 (97%) of all active PBSPs met the 14-day criteria. In addition, of those sampled, six (100%) received necessary consents within 30 days of plan development. Overall, based on the tracking grid, 116	

		(86%) received necessary consents within 30 days of plan development. Although progress had been made in the development and implementation of PBSPs, the Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to improve the quality of PBSPs, including developing adequate operational definitions for replacement behaviors, ensuring adequate behavioral objectives for target and replacement behaviors, and providing more conspicuous and robust strategies designed to teach replacement behaviors (i.e., specifically identify SAP if in place). In addition, the Facility should ensure that all PBSPs receive consent and approval prior to implementation.	
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, a sample of 14 individuals who had an ISP meeting within the last six months and who also had PBSPs were selected and their current PBSP as well as Monthly PBSP Progress Notes, for three consecutive months (i.e., March April and May) were examined. Based on the PBSP Master List, dated 7/11/13, this sample of 14 individuals reflected 10% of total number (N=135) of individuals with active PBSPs. As noted above, Monthly PBSP Progress Notes were completed for 13 (93%) of the individuals sampled. At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 13 (93%) of the individuals sampled. Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 11 (79%) of those sampled. In addition, target and replacement behaviors were consistent across the PBSP and monthly PBSP progress notes for 11 (79%) of the individuals sampled. Monthly notes contained timely target and/or replacement behavior data as well as appeared to be completed in a timely fashion (within 30 days) for 11 (79%) of the individuals and appeared to be completed in a timely fashion (within 30 days) for 11 (79%) of the individuals sampled. Lastly, the clinical notes appeared to be descriptive, integrative, and offered clinical insight (beyond the graphed data) in the monthly notes for 10 (71%) of the individuals. Overall, although the Monthly PBSP Progress Notes continued to evidence improvement over time, some of the monthly notes did not appear to include adequate operational definitions, expected data, and/or reflect timely and adequate monitoring and review of individual progress on PBSPs. Closer review of graphic displays of data showed progress since the Monitoring Team's last visit. That is, PBSP monthly progress notes evidenced graphs with Y- and X-axes that were adequately labeled for 14 (100%) of the notes reviewed. However, only 10 (71%) 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 graphed data difficult (e.g., Individual #46 and Individual 284), the use of data markers that did match the legend and/or the definitions provided on the data	Noncompliance

		sheet (e.g., Individual #127, Individual #34, and Individual #70), and the illegibility of the scale on the Y-axis and legend (i.e., Individual #70). The continued inclusion of condition change lines or other demarcations on graphs to illustrate changes in programming or other variables, however, was evident in 10 (71%) of the individuals' monthly notes. The exceptions included Individual #127, Individual #183, Individual #70, and Individual #284, where these interpretive aids were not utilized. In addition, the use of more divergent data markers (e.g., open circles) facilitated the interpretability of the graphs for a number of individuals (e.g., Individual #73, Individual #306, Individual #202, and Individual #183. As presented with regard to Section K.4 of the Settlement Agreement, descriptions related to the collection of inter-observer agreement (IOA) and/or treatment integrity (competency-integrity checks) was noted in one or more of the monthly notes of 12 (86%) and 13 (93%) of the individuals sampled, respectively. However, as previously discussed, IOA and treatment integrity data was only presented in the monthly notes for 11 (79%) and 12 (86%) individuals, respectively. Overall, the quality of monthly PBSP progress notes continued to reflect progress as evidenced by findings of the current review. As noted above, provided documentation continued to evidence substantial efforts at the collection and monitoring of inter-observer agreement data since the Monitoring Team's last visit. Previous Monitoring Team's reports had documented the Facility's improving progress at collecting IOA data. That is, the Facility previously reported completing 65 probes in a four-month period (ending February 2012) and 335 IOA probes in a subsequent six-month period (ending September 2012), reflecting a significant increase in the number of completed IOA probes conducted over time. Currently, in addition to findings based on the sampled monthly PBSP progress notes, summary data provided by the Facility (in the Presentation Book for Section K) reflected a significant increase in the number of recently completed IOA probes compared to previously noted rates. More specifically, it was reported that 1253 IOA probes were completed between 11/1/12 and 5/31/13. Data indicated that these probes produced an estimated average agreement of 88.1% (range of 49.2% to 96%), as well as showed individual probe estimates ranging from 0% to 100%. More detailed monthly summary data highlighting the number of PBSPs on which IOA probes were conducted also was provided. More specifically, the Facility reported that on average IOA probes were conducted on 71.7 PBSPs per month (range of 43 to 90 each month), from November 2012 through May 2013. In addition, the Facility reported that on average these IOA probes were conducted on 53.4% of the total number of active PBSPs per month (range of 31.9% to 63.7% each month) during that same time period. The Facility acknowledged the less than acceptable average estimate reported for May 2013 (i.e., 49.2%) as well as the fact that the goal of one IOA probe per PBSP per month had not yet been obtained. However, these findings reflected a substantial improvement in the completion of IOA since the Monitoring Team's last	

		visit. It should be noted that the Facility appeared to complete some IOA probes using a group format. That is, it appeared that IOA probes were conducted simultaneously using multiple staff and behavior data was selected from one of the probes where at least one comparison produced an estimate agreement of at least 80%. Although this appeared to be a method to compare the data collected by multiple informants, it appeared to be a somewhat unorthodox method of collecting IOA data (i.e., usually consisting of two independent observers). Consequently, it was unclear to the Monitoring Team if the data collected during these group sessions was included within the IOA data provided. In addition, only summary data was provided and, as a result, it was unclear what percentage of IOA probes were completed on target behavior and/or replacement behaviors. In addition to the collection of IOA data, documentation evidenced continued collection of competency/integrity checks since the Monitoring Team's last visit. As reported in the Monitoring Team's previous report, two competency-integrity formats were needed due to the diversity in formats at that time of PBSPs. Currently, however, the rubric utilized for conducting competency-integrity checks had been integrated into the most recently revised PBSP format. That is, specific elements within each PBSP were used as embedded items for the competency-integrity checks. This included a format that allowed collection of data, reflecting "correct" or "incorrect" for each embedded item, based on either informant verbal report or direct observation of the informant by rater(s). As discussed with regard to Section K.11 of the Settlement Agreement, the Facility reported that 100% of the active PBSPs were developed using this new format. This reported progress was consistent with findings from the current review of sampled PBSPs. That is, all of the sampled PBSPs were developed mirroring this new format, and, consequently, identified embedded items to be used during competency-integrity checks. Currently, summary data the Facility provided reflected a significant increase in the number of completed competency-integrity checks compared to previously noted rates. More specifically, as reported in the Monitoring Team's previous report, approximately 496 competency-integrity checks (across 15 residential sites) were completed between April 2012 and September 2012. Currently, it was reported that 799 competency-integrity checks were conducted between 11/1/12 and 5/31/13. Summary data indicated that these checks produced an estimated average integrity of 94% (ranging between 92.4% to 96.5% average monthly scores). Provided summary data also indicated that checks estimated individual integrity scores ranging from 27% to 100%. More detailed monthly summary data was also provided that reported the number of PBSPs for which competency-integrity checks were conducted. More specifically, the Facility reported that these checks targeted, on average, 84.6% of the total active PBSPs per month (between November 2012 and May 2013). That is, summary data indicated	

		that, across November 2012, December 2012, January 2013, February 2013, March 2013, April 2013, and May 2013, competency-integrity checks were completed on 73.1%, 75.2%, 79.7%, 68.1%, 96.3%, 100%, and 100% of active PBSPs, respectively. In general, it appeared that improvements were observed over time in the number of checks completed, mean average scores (including range), and in the percentage of PBSPs for which competency-integrity checks were completed. It should be noted that four examples of inter-rater reliability estimates for competency-integrity checks were provided for review. Overall, improvement in the quality of ongoing documentation and monitoring, specifically with regard to the collection of IOA and integrity data was observed. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to improve elements found within the notes, including the use of graphic conventions that aid interpretability.	
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.	According to provided summary data, as of 5/27/13, the Facility reported that 135 (100%) of current PBSPs were converted to a recently revised PBSP format. This would suggest a noted improvement since the last Monitoring Team visit given that the previous estimate provided by the Facility (i.e., noted in the previous report) indicated that 39% of active PBSPs were written in the most current format. In an effort to more closely examine the format of current PBSPs, a sample of 14 individuals who had an ISP meeting within the last six months and who also had PBSP were selected and their current PBSP was examined. Based on the PBSP Master List, dated 7/11/13, this sample of 14 individuals reflected 10% of total number (N=135) of individuals with active PBSPs. Closer review of the sampled PBSPs revealed that 14 (100%) were completed using the most recent streamlined PBSP format. This format appeared similar to previous versions, although the newer version contained additional content targeting the potential revision and reduction of intrusive interventions. Overall, the new format, like the previous format, appeared likely to improve the accessibility, understanding, and implementation by staff. Sampled plans appeared similarly structured, three to five pages in length (most were four or less pages), concise, and relatively user-friendly. However, as previous discussed with regard to Section K.9 of the Settlement Agreement, some of the sampled PBSPs were missing critical elements or contained inadequate elements within the plans. As currently reported, the Facility worked to ensure that PBSPs were written at or below a 7.0 grade reading level in an effort to increase the likelihood that direct support professionals understood and implemented them correctly. Readability levels of PBSPs were estimated using the Flesch-Kincaid Grade Levels (using Microsoft Word) for all PBSPs. These readability levels were reportedly monitored by the BSC and, when necessary, re-written to meet this criterion. According to provided summary data (PBSP Master List, dated 6/24/13), 100% of the PBSPs (N=135) had readability levels below a	Substantial Compliance

		7.0 grade level and analysis indicated an average reading level of 5.8 (range of 3.4 to 6.9). Currently, closer review of the sample of PBSPs revealed that 14 (100%) were scored at or below a 7.0 grade reading level. That is, the sampled PBSPs revealed an average grade reading level of 5.8 (with a range from 4.0 to 6.9). Overall, substantial progress was noted in ensuring that PBSPs were written so that direct support professionals could understand them effectively. Consequently, the Facility met 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, progress also was noted in the provision and monitoring 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). According to verbal reports from the Director of Behavioral Services as well as the Director of Competency Training and Development (CTD), there were no significant or qualitative changes to the overall structure of NEO and OJT. However, slight improvements were reported in the methodology, scheduling, and monitoring of trainings. These changes are described below. The Monitoring Team's previous recommendations included ensuring that psychologists had sufficient time to provide competency-based training of PBSPs to direct support professionals, especially new hires. According to the Director of CTD, the prescribed training "window" (i.e., for the completion of required trainings) for new hires was extended from five to seven days. That is, the Facility now provided seven working days for new hires to complete their targeted five days of required OJT training. In addition, reports indicated that staff members from CTD assisted psychologists and psychology assistants in scheduling appointments with new hires to ensure sufficient training time. According to the Director of Behavioral Services, a limit of training up to three PBSPs per day during OJT had been set in an effort to avoid overwhelming new hires and facilitating better retention of important information. In addition, verbal reports from the Director of CTD indicated that more time was available and would be provided, if necessary, to ensure adequate training during OJT. Since the Monitoring Team's last visit, efforts to ensure the quality of competency-based trainings by behavioral services staff included the revision of prescribed methods of instruction. That is, verbal reports from the Director of Behavioral Service as well as provided documentation evidenced new written guidelines, developed through consultation with Texas Tech University, that highlighted critical elements of competency-based training. For example, the new guidelines required at least two trainers, copies of relevant PBSPs and data cards, as well as required demonstration of all skills identified in the PBSP by each staff trained. Indeed, the focus of the guidelines	Noncompliance

		appeared to be centered on trainee demonstration of skills, trainer performance feedback, and objective ratings (using competency-integrity checks) of trainee competency. In addition, the guidelines outlined a system for tracking specific information (e.g., PBSP number, date, trainee names, and scores). Recent onsite direct observation of competency-based training of a PBSP (of Individual #315), for example, evidenced the utilization of these prescribed methods. The Monitoring Team previously recommended that the Facility prioritize the training of key professional and support staff in an effort to provide onsite resources for direct support professionals. That is, Home Team Leaders, Assistant Home Team Leaders, Residence Coordinators, and/or QDDPs, for example, would be those most likely to be in positions to model accurate and effective programming (e.g., skill acquisition plans, PBSPs, and data collection) for direct support professionals. In response, based on descriptive information listed in Section K.12 of the Section K Action Plan, the Facility appeared to have recently completed trainings (in March 2013) for selected experienced staff, including Residential Coordinators, Home Team Leaders, and Assistant Home Team Leaders. Supplemental evidence of these targeted trainings, including attendance rosters and/or training logs, was not found, but also was not requested. However, evidence of the completion of substantial trainings for direct support professionals targeting PBSPs was provided. More specifically, provided documentation evidenced listings of trainings on PBSPs for new hires as well as current staff between November 2012 and April 2013. During this time, data indicated that a total of 88 new hires were trained on PBSPs across 14 residential programs. In addition, data indicated that a total of 209 current staff received training on PBSPs (involving 62 PBSPs) during this time across residential, day program, and vocational settings. Review of the implementation status of currently active PBSPs, using summary data on the PBSP Master List (tracking spreadsheet), dated 7/11/13, revealed that 131 (97%) of the total number of plans were implemented following competency-based training completed within the last 12 months. The Monitoring Team had also previously recommended that the Facility ensure that part-time or pulled direct support professionals received competency-based training. As noted in the last report, efforts to ensure and monitor the training of pulled staff had included the use of a "Pull Staff Member Orientation Page." At that time, documentation revealed that the use of this system was implemented at select residences, but not across the entire campus for all pulled staff. In addition, at that time, there was no evidence provided to indicate that staff providing the training to part-time or pulled direct support professionals were judged to be competent trainers. Currently, provided documentation evidenced the continued use of this system (i.e., additional examples of completed Pull Staff Member Orientation Page). However, provided documentation did not evidence a systematic and efficient process for tracking the training of all pulled staff (i.e., other than requesting individual training sheets). It should be noted that the Monitoring Team recently observed one example of where this system was not implemented as prescribed.	

		More specifically, during this most recent review, a Monitoring Team member's visit to one of the residential programs revealed that prescribed training as well as the documentation of that training (using a Pull Staff Member Orientation Page) had not been completed for one of the pulled staff interviewed. Currently, verbal reports from the Director of Behavioral Services and the Director of CTD indicated that a new computer-based data management system recently was implemented (in June 2013) to maintain and monitor trainings conducted for individual PBSPs across all staff (e.g., regularly assigned as well as pulled staff) at the Facility. Descriptions of this system suggested that selected search and/or output criteria could be used to determine, for example, the training completed for each individual PBSP and/or the training record for each staff member. Indeed, provided examples of output appeared to suggest that analysis could be applied to the individual, direct support professionals, or at the program level. Ultimately, this electronic system could facilitate quick analysis of the training needs across all individuals served at the Facility. Because this system just recently was implemented, the Monitoring Team will plan to closely examine its effectiveness in improving training and monitoring of training needs during the next visit. Lastly, as presented with regard to Section K.10 of the Settlement Agreement, progress was evident in the increasing completion of competency-integrity checks since the Monitoring Team's last visit. Currently, summary data indicated that 799 competency-integrity checks were conducted between 11/1/12 and 5/31/13 and that these checks produced an estimated average integrity of 94% (ranging between 92.4% to 96.5% average monthly scores). In addition, the Facility reported that these checks targeted, on average, 84.6% of the total active PBSPs per month (between November 2012 and May 2013). In general, it appeared that improvements were observed over time in the number of checks completed, mean average scores (including range), and in the percentage of PBSPs for which competency-integrity checks were completed. Although progress had been made in the provision of competency-based training of PBSPs, the Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to populate the new computer-based data management system in an effort to more closely monitor staff trainings conducted for all PBSPs, especially with regard to pulled staff who are utilized across the Facility.	
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	At the time of the recent onsite visit, in addition to the Director and Assistant Director of Behavioral Services, LBSSLC employed nine other professionals (including Associate Psychologists and Behavior Analysts). Of these 11 staff, four were currently BCBAs. In addition, reports indicated that five Psychological Assistants were employed. Currently, there were two vacant Psychological Assistant positions.	Noncompliance

	professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	As of 7/8/13, reports 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 carry caseloads, an approximate average ratio of 1:23 psychologist-to-individual served was determined. With five Psychological Assistants currently employed, the Facility exceeded the ratio of one Psychological Assistant for every two professionals that currently developed PBSPs. The Facility was rated as being in noncompliance with this provision because a number of professionals within the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification as well as the quality of programming at the Facility. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to support psychologists in their successful completion of required academic coursework as well as continue to ensure required supervision according to the Behavior Analyst Certification Board eligibility guidelines.	

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 Monitoring Team's last visit; o Name and degrees of all primary care providers that were new to the Facility since the Monitoring Team's last visit; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing CPR training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since the Monitoring Team's last on-site review, copy of Continuing Medical Education (CME) for each primary care provider; list of CME credits according to topics reviewed; and list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of Infection Control Committee meetings during the prior six months; o Minutes of Skin Integrity Committee meetings during the prior six months; o Most recent results/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 each PCP, two most recently completed quarterly medical reviews from each assigned residence; o For any medical staff meetings (i.e., morning provider meetings, etc.) copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for a recent week prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit. Including separate reports/data of external medical peer review audits from internal medical peer review audits (both general medical and medical management audits), including information concerning number of corrective action plans, and QA Department follow-up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included 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. Submitted, requested information included location at time of death, whether DNR, whether receiving hospice services, ambulatory status, and whether supplemental oxygen was prescribed as part of routine care. Date of any ethics committee meeting that

	reviewed the individual's terminal course, if applicable; 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 made prior to last Monitoring Team visit which had follow-up closure or action steps completed); o Notes and orders for any Do Not Resuscitate (Order) (DNRs) and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (clinical/administrative) that remained incomplete/outstanding; o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination; o Specialty clinic schedule per month for past six months (including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for reasons other than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow-up appointments were made, the list of refused appointments for which a follow-up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of all outside consultations for medical purposes for the past six months, categorized by specialty including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for reasons other than refusals, the list of missed appointments (refusals) for which follow-up appointments were made, the list of missed appointments (non-refusals) for which follow–up appointments were made, the list of refused appointments for which a follow–up visit was completed, the list of missed appointments (other than refusals) for which a follow-up visit was completed, and the list of missed appointments for all reasons still pending; o For one individual from each residential home, copies of: all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit; and all integrated progress notes commenting on consultant reports (medicine and surgery inclusive of subspecialties), (agreeing or reason(s) not agreeing by PCP), any documentation of notification of IDT concerning consult report and PCP response, and any ISP addendum related to the consultant report; o List of individuals: A. with tracheostomies; B. with fractures, date of fracture, the type of fracture (i.e., compound, simple, stress, etc.), the bone fractured (including location); C. with injuries requiring visit to ER or hospitalization since the last on-site review; D. with pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether taken to ER or hospitalized, since the Monitoring Team's last on-site review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of 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 (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last DEXA scan or statement if not completed, copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake and Vitamin D intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test; o For those going to the ER and not hospitalized, copy of IPN from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility record orders, IPN/Infirmary progress notes, follow-up to any recommendations, for the 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations); o For those admitted to hospital, copy of IPN from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, 10 most recent hospitalizations that have returned for at least 30 days (in order to allow completion of recommendations); o For these same 10 most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; o Infectious disease data per quarter, by category of infection, for the last two quarters; o Summary report or trend analysis of infectious disease/communicable disease for the last two quarters; o Avatar pneumonia tracking forms/pneumonia data from Avatar database 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 (i.e., prior year, by month) for the following: a) pneumonia, b) decubitus ulcers, c) Urinary Tract Infection (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 (i.e., type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes); o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit, date of prior visit to the neurologist for these same individuals; o List of those with status epilepticus since the last Monitoring Team 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 last monitoring team visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals with diagnosis of seizure disorder on zero, one, two, three, four, and five Antiepileptic Drugs (AEDs); o Numbers and percentages of persons on older AEDs (e.g., Phenobarbital, Dilantin, Mysoline, and Felbamate); o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes, or other concerns addressed by this committee; 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 (both 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 Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at morning provider meetings for period of 30-60 days prior to the Monitoring Team's visit, any documents providing evidence of closure (i.e., minutes of medical staff meeting, copy of 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, Human Rights Committee (HRC) approval, relevant assessments, ISP

	entries, any general discussion record, action plan, and IPN entries; o Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; o ISPAs addressing missed appointments or refusals for the past three months (i.e., for mammograms, colonoscopies, and off-site and on-site consultation appointments); o List of missed medical appointments, with reasons, for the past six months; o Presentation Book for Section L; o Texas Department of Aging and Disability Services (DADS) Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women age 21 to 65, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful). If pelvic not done, the reason/indication, and if pap smear not done including the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; o For each of the following individuals, copies from the active record: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, 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 Personal Support Plan/Individual Support Plan (PSP/ISP) and subsequent addendums, most recent BSP, past three medical quarterly reviews: Individual #313, Individual #114, Individual #283, Individual #74, Individual #284, and Individual #139; o Minutes of the morning provider meeting with handouts during the Monitoring Team visit; o Medical Department meeting minutes since the Monitoring Team's last visit; o Corrective actions QA audit follow through for external/internal medical provider audits November 2012 and February 2013; o Document: "LbSSLC Lab Point of Care Testing;" o Definitions of "Resuscitative Status I, II, III;" o Corrected database for MD Quarterly Completion dates, as of 7/12/13; o Copy of any ethics committee meetings on those with DNR; and o State office DNR Policy.

	▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; o Leah Shults, RN, BSN, Medical Program Compliance Nurse; o Resurreccion Barranda, MD; o Ricardo Rodriguez, MD; o Grazyna Thomas, PA-C; o Richard Weddige, MD, Staff Psychiatrist; and o Shiraj Vahora, MD, Staff Psychiatrist. ▪ **Observations of**: o Individual #323, Individual #258, Individual #37, Individual #312, Individual #226, Individual #217, Individual #17, Individual #304, Individual #104, Individual #167, Individual #191, Individual #62, Individual #139, Individual #324, Individual #21, Individual #89, Individual #6, Individual #195, Individual #293, Individual #181, Individual #211, Individual #161, Individual #225, Individual #176, Individual #196, Individual #29, Individual #215, and Individual #78; and o Provider morning meetings, on 7/9/13, 7/10/13, and 7/11/13.
	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 and internal general medical audit and medical management audits, medical quality improvement audits, and monitoring of preventive procedure completion. o These monitoring/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. o The monitoring tools did include adequate methodologies, such as record reviews, review or provider morning meeting minutes, closure logs, etc. 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). These sample sizes were adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: Medical Compliance Nurse, Medical Director, PCPs, Clinic RN Manager, and Clinic LVN. o The staff responsible for conducting the audits/monitoring appeared to be 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. Inter-rater reliability had been established between Facility staff and the external medical peer review auditor. ▪ The Facility used some 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. o However, the quality of the data maintained in the databases was noted to be incomplete and inaccurate for some of the databases. Some of the databases, such as the closure logs, appeared complete. For other databases, the Medical Department had to provide corrected information to the Monitoring Team. For other databases, there was conflicting data for the same subject, such as cases of pneumonia. o Examples of data or monitoring results that were not included were tracking closure of recommendations from the administrative death reviews, reviewing the quality of the annual medical assessment for accuracy, assessing the entries in the Active Problem List to ensure updated information is included, and reviewing the adequacy of family histories and transition information in the annual medical assessment. ▪ The Facility presented some data in a meaningful/useful way, but problems were 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 (e.g., above comments on the annual medical assessment). o 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 L: L.2, L.3, and L.4. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying for example the need for more timely annual medical assessments.
	Summary of Monitor's Assessment: The Medical Department remained fully staffed without turnover. The provider morning meetings were efficient and effective, as well as sustainable. Post-hospital ISPAs, other concerns needing follow-up, and open record reviews all had a rigorous closure system. There were high rates of completion of preventive procedures. It was noted that PCPs were not always in attendance at post-hospital ISPAs, and the PCP would be a valuable member of the team at such meetings. Some of the databases appeared to have significant information management problems, which made evaluation difficult. As the Medical Department was not aware of these problems, it appeared the Medical Department had not fully realized that a dependable information management system was necessary to guide the department in planning and implementing quality care initiatives. Attention to the quality of the Medical Department documentation content was needed. The Monitoring found the Facility to be in noncompliance with Sections L.1, L.2, L.3, and L.4.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and DNR Orders. <u>Staffing and Administration</u> For the census of 211 individuals, as of 7/8/13, there were four PCPs responsible for the clinical duties of this population. This included a Medical Director, two other primary care physicians, and a Physician Assistant (PA). Support staff included a Medical Program Compliance Nurse, an Administrative Assistant, and a Medical Department Office Clerk. The Medical Director had a caseload of 18 individuals. Other PCPs had caseloads ranging from 64 to 66 individuals. 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 entitled "Active Employee Course Participation Report: BLS for Health Care Providers (CPR/AED)" dated 5/30/11 to 5/30/13. 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 one of these PCPs. This PCP had completed 18 CME hours. The topics covered included: hospice and palliative care, trauma and critical care, and update in general internal medicine. 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. The majority of the topics covered included areas of importance to primary care and the individuals residing at LBSSLC. There were no topics specific to intellectual disabilities/ developmental disabilities (ID/DD). Additional CME was provided to the PCPs through a neurologist on clinic days when that specialist was scheduled to see individuals. Focus of the CME was specific to drug therapy and seizure management. These CME activities occurred on 10/26/12 (Neurology grand rounds: Side effects of newer antiepileptic drugs), 1/25/13 (Neurology grand rounds), and 4/26/13 (status epilepticus). <u>Physician Participation In Team Process</u> For the three morning provider meetings observed, there was a signed attendance roster in three of three (100%) meetings. Departments represented at the morning provider meeting on a daily basis included: Medical Department, Psychiatry, Dental Department, Pharmacy, QDDP representative, Psychology, Nursing (i.e., Hospital Liaison Nurse, Infection Control Nurse, RN Case Manager Supervisor), PNMT, and QA Department. Departments represented at the morning provider meeting on a weekly or periodic basis included: Nursing Executive	

#	Provision	Assessment of Status	Compliance
		office and Laboratory. For the three morning provider meetings observed, there were four hospitalizations (i.e., Individual #181, Individual #136, Individual #281, and Individual #9) during this time. Based on the Monitoring Team's observations and review of documentation: ▪ For three of three (100%) morning provider meetings observed, critical clinical questions were raised with interdisciplinary discussion for both on-call concerns as well as those individuals that were returning from the hospital. ▪ Formal record review: for two hospitalized individuals (i.e., Individual #181 and Individual #281), there was a request for a formal record review to determine preceding events, monitoring intensity, etc., before the onset of acute illness. For the other two individuals for whom an open record review was not assigned during the Monitoring Team's visit, one had repeated hospitalizations with prior open record review ordered on 5/29/13, and remained in the hospital for over a month, and the other individual had been subsequently transferred to an acute care long term care facility, with prior record review ordered on 5/22/13. These two open record reviews had been completed, as they were no longer pending. ▪ Closure discussions: there were three prior concerns with assignments for follow-up, which were presented at the provider morning meetings. ▪ Requested ISPAs reviewed: there were six brief summaries of ISPAs that had been assigned to IDTs in responding to concerns referred by the morning provider meeting. These were discussed and all were accepted as resolving/answering the concern. ▪ There were five ISPAs assigned due to post-hospitalization or consultation follow-up concerns. ▪ Infection control updates: during the three morning provider meetings, there was one infection control update presented. ▪ Summaries of completed consultations: during the three morning provider meetings, 19 summaries were presented of completed consultations or updates of consultations. ▪ Dental Department updates: the Dental Department provided brief updates/ information during zero of three morning provider meetings. ▪ PT/OT/ST and PNMT updates: the PT, OT, ST and PNMT presented updates during one of three morning provider meetings. ▪ Skin integrity updates: skin integrity reports/updates were provided at one of three morning provider meetings. ▪ Discussion of significant weight change: there was a discussion of individuals with significant weight loss or gain at zero of three morning provider meetings. ▪ Hospital Liaison Nurse updates: the Hospital Nurse Liaison reported an update	

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		for four of four (100%) hospitalizations during the monitoring observed meetings. ▪ On-call PCP participation: for the three morning provider meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in three of three (100%) meetings. ▪ Attending PCP participation: the attending PCP for the individual (when not the on-call PCP) participated in the discussions of health status changes/on-call concerns in three of three (100%) meetings. ▪ The Medical Director provided two administrative/clinical announcements in two of three morning provider meetings. The strengths noted at the morning provider meeting included the following: ▪ The meetings were efficient and thorough, accomplishing the necessary morning clinical care communication and decision-making in an hour or less each business day. ▪ There was good attendance at all meetings observed. ▪ There was a thorough tracking system for a number of the processes utilized at the morning meeting to ensure all items assigned were followed to closure. o The volume of closures reflected the activity of the morning meeting as follows: ▪ For the first quarter of 2013, there were 58 items identified as needing closure, and all were followed to closure. Closure required written evidence of the resolution of the concern, for instance, training rosters and training material used as evidence when the closure required training. ▪ For the second quarter of 2013, there were 50 closure times tracked, and 49 were closed, and one item continued to be followed. ▪ For July 2013, there were four closure items identified and all remained open. For each closure item, evidence was provided and kept on file for easy retrieval. o Requested ISPAs also were tracked through a monthly log, with information that included the reason for the referral, the date of the request or repeat request, the date presented at the morning meeting, whether recommendations were accepted at the morning meeting, and the contact QDDP. ▪ For May 2013, 25 ISPAs were requested. All were subsequently presented to the morning provider meeting, and one had been returned to the IDT for further review. ▪ In June 2013, there were 14 requests for ISPAs by the morning provider meeting. From the tracking log, it appeared 10 had	

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		been accepted, one was sent back to the IDT for further review, and three remained pending. ▪ For July 2013, there were 10 requests listed. One had been accepted and nine were pending. o For June 2013, the log-tracking sheet indicated that there had been six open record reviews assigned. All had been reviewed at the morning meeting. Five of six had recommendations. For July 2013, there were two open record reviews assigned, and these remained pending. The Medical Director had recently indicated that the report of the open record review was due to the morning provider meeting one week from the assigned date. The morning provider meeting, due to its efficiency in time and effectiveness in accomplishing the needed clinical tasks, appeared to be a sustainable process for the Medical Department, with thorough documentation of all action steps. There were no weaknesses or concerns identified. <u>Medical Staff Meetings</u> Medical Departmental meetings occurred on 10/9/12, 11/14/12, 12/17/12, 1/14/13, 2/12/13, 2/15/13, 4/18/13, 4/24/13, 6/21/13, and 6/24/13. A breadth of topics were covered, including the schedule for completing the medical quarterly review, PCP attendance at medical response drills, in-service on use of Macrodantin for chronic UTI suppression, urinary bladder irrigation, improving the communication between the hospital attending and the receiving PCP at LBSSLC, delay in filing dictated IPNs in the active record, the Medical Department quality clinical indicators, completion of corrective action plans from the peer review audits, an in-service on high frequency chest wall oscillation treatment, the results of the February medical peer review audit, preventive screening, expanding laboratory testing at LBSSLC, Clostridium difficile serial testing, decubitus wound care, database management of immunization status, and Therapool usage. The Facility received a Clinical Laboratory Improvement Amendments (CLIA) waiver on 4/25/13 for a period of two years. This allows the Facility to run selected laboratory tests following CLIA guidelines. Requirements included writing procedures for each test, creation of log quality controls for the various tests, temperature logs, and tracking test supplies for expiration date and lot numbers. Tests currently completed or that would be completed once supplies are received included: urinalysis, fecal occult blood, Strep A screen, Protime/International Normalized Ratio (PT/INR), Influenza A/B screen, Hemoglobin A1C, urine pregnancy test, glucose, and gastric occult blood. The goal was to make available tests that could be provided with quality results, in a shorter amount of time, allowing for more rapid treatment.	

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		Routine Care A list of dates of the last two annual medical assessments and physical exams were submitted in a document entitled "Tracking Annual Physical Exams 6/17/13." The list totaled 214 names. Individuals newly admitted in the prior year, with only one annual exam date were omitted, leaving 205 individuals listed. Of these, 144 out of 205 (70%) of the recent annual medical assessments and physical exams were completed within 365 days of the prior assessment. For 23 individuals, a copy of the 23 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 or the most current annual medical summary was within 365 days of the scanning date of 6/10/13. For the 23 individuals, timeliness compliance was 20 out of 23 (87%). ▪ For the 23 most recent annual medical assessments, there was an interval history included as part of the document in 23 of 23 (100%) reviews. ▪ For the 23 most recent annual medical assessments, the major active problems listed had plans of care addressing each of these problems in 23 of 23 (100%) assessments. ▪ For the 23 most recent annual medical assessments, 23 (100%) addressed smoking history. ▪ Family history was adequate/helpful or not available due to a history of adoption in 10 of 23 (43%). The family history was detailed in the 2012 annual medical summary, but had been dropped in the 2013 review for one individual (Individual #30). ▪ A discussion of readiness/requirements for transition to the community was included in 17 of 23 (74%). The transition information appeared at times to have been pasted from an ISP or other document for some of the annual medical summaries (i.e., Individual #126, Individual #79, and Individual #300). For Individual #213, the transition status was addressed in the 2012 annual medical summary, but not in the 2013 annual medical summary. It also was noted that there appeared to be a general trend of less transition information listed in the 2013 annual medical summaries than in the 2012 annual medical summaries. It is recommended that a standardized format be utilized in completing this section. 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	

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		L.1. These individuals are listed in the documents reviewed section. The selected individuals had one or more high-risk areas as determined by the at risk process. This allowed the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included the preventive care flow sheet, physician orders for the prior one year, IPN for the prior one year, the most recent three quarterly medical reviews, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one year, the integrated risk rating form, the most recent health care management plan/risk action plan/integrated health care plan, the most recent annual medical assessment and physical exam, DNR forms if applicable, 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. Review of the six medical records included the following: ▪ Six of six (100%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in four of six (67%). ▪ Six annual medical assessments were reviewed for a smoking history and/or substance abuse history, and six (100%) contained this information. ▪ An adequate family history was documented (or attempts at obtaining this information were documented) in zero of six (0%) records. For two of six (33%), information was provided on one relative, but no information was available concerning other relatives. When it is known if siblings, parents, and other relatives do not have specific illness, this would be important to document. ▪ Six of six (100%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed and of the six DG-1s reviewed, four (67%) had updated diagnoses and maximized the information allowed by the DG-1 form. ▪ These six medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In six of six (100%), the SOAP format was used, and included date and time on the IPN. ▪ For each of six medical records reviewed, three events were reviewed in which documentation of vital signs in PCP IPNs would be applicable. For the six medical records, 18 PCP IPNs were reviewed. Of these 18 IPNs, 16 of 18 (89%) included documentation of vital signs. <u>Quarterly Medical Reviews</u> Two sets of data were submitted for information concerning timely completion of quarterly medical reviews.	

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		A document was submitted, entitled "MD Quarterly Review Tracking from November 1, 2012 through May 2013." Data was submitted for 205 individuals. The data indicated tracking of medical quarterly reviews for these individuals since November 12, 2012. The dates of completion, as well as the due dates, were entered into the database. The date of the prior completed medical quarterly report was also entered. The Medical Department needed to further review this data, because at times three dates were accumulated, and at times there was duplication of dates, and missing entries. The Monitoring Team was able to determine that 350 quarterly reports were completed that were due in the six months prior to May 31, 2013. The Medical Department indicated that four quarterly medical reviews were to be completed in a year, in addition to the annual medical assessment. The total expected for the prior six months, according to this document, was (205 x 2) 410, for a compliance rate of 85 percent. After the Monitoring Team reviewed this database with the Medical Department, a corrected document was submitted. The corrected document was tabulated manually. The last two completed quarterly medical review dates for each individual were submitted, and there were 208 names listed. The compliance rate was 100 percent. It also appeared that the most recent quarterly medical review, based on the date of the prior review, was completed in a timely manner in 100 percent of quarterly medical reviews. The Monitoring Team's finding of inaccurate information followed by a corrected, handwritten copy indicated that the information was available. However, it indicated that Facility staff had not reviewed the list for accuracy. Given that this document was an important quality improvement tool to guide the Medical Department in determining the status of compliance with individuals' medical quarterly reviews, this information should have been regularly reviewed, and the errors should have been identified. In addition, the information should be used to determine whether systemic concerns needed to be addressed through a quality improvement initiative. Contents of the quarterly medical review were evaluated for individuals from each residence. The request was for two of the most recently completed medical quarterly reviews, from each assigned residence, for each PCP. It was noted that for some residences, a copy of the two most recent medical quarterly reviews were submitted for every individual. A total of 51 quarterly medical reviews for 27 individuals were evaluated to assess completeness: ▪ All PCPs used a template format. ▪ Fifty-one of 51 (100%) included the date of the quarterly review completion. ▪ Major diagnoses were listed in 51 of 51 (100%) medical quarterly reviews. ▪ The last three monthly weights or equivalent information was not applicable for	

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		two individuals (i.e., new admissions, etc.). The last three monthly weights or equivalent information were recorded in 45 of 49 (92%) medical quarterly reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in 18 of 19 (95%) medical quarterly reviews. ▪ There was documentation of changes in medication in 23 of 51 (45%) medical quarterly reviews. It was noted the template did not include an area for review of changes in medication. ▪ Important/abnormal labs and drug levels were documented in 13 of 51 (25%) medical quarterly reviews. ▪ Important/abnormal results of radiographic and other tests were documented in 26 of 51 (51%) medical quarterly reviews. The template did not have an area for review of abnormal lab values nor recording abnormal results of other tests. In its response to the draft report, the State indicated that abnormal radiographic or other abnormal diagnostic labs/ x-rays and other tests were documented in the "Comments Section" of the Medical Quarterly Review. However, the template and examples submitted for the Medical Quarterly Review did not include a heading for "Comments." This would be a valuable addition to the template (with an explanation of what would be placed under "Comments," such as significant lab and radiographic findings) to standardize the expectation that abnormal test results should be included in the quarterly medical review, as well as to standardize the location of this information on the template. ▪ For individuals that were hospitalized or had an ER visit, there was documentation of ER visits, and hospitalizations with dates and discharge diagnoses/treatments in eight of nine (89%) medical quarterly reviews. ▪ There was documentation of important consultation results (brief) in 44 of 51 (86%) medical quarterly reviews. The quality of the information varied. Some documents listed the consult type and the date, but did not provide any summary of results. Other consult documentation provided detailed results of the visit. For the six medical records reviewed, each included three or four quarterly medical reviews. Five of six (83%) had a current quarterly medical review. For one medical record, the most recent quarterly review submitted was in February 2013. For an additional individual, it appeared there was a current quarterly medical review (with a current "filed" stamp date of April 2013), but the date had not been changed from the prior quarterly medical review. However, the information on this form had been updated.	

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		Access to Specialists The following chart indicates the off-site appointments made and the off-site appointments completed:	

Specialty	Appointments Scheduled	Appointments Completed	Percentage Completion
Allergy/Asthma	12	9	75%
Cancer/Oncology	6	1	17%
Cardiology	100	27	27%
Dermatology	17	9	53%
ENT	29	6	21%
Family Medicine	6	1	17%
Gastroenterology	132	49	37%
General Surgery	31	8	26%
Gynecology	3	0	0%
Hematology	20	9	45%
Hospital/Surgicenter	42	16	38%
Infection Clinic	3	3	100%
Internal Medicine	3	2	67%
Nephrology	15	7	47%
Neurology	34	7	21%
Neurosurgery	1	0	0%
Ophthalmology	25	7	28%
Orthopedics	15	7	47%
Pediatrics	2	0	0%
Podiatry	1	0	0%
Psychiatry	1	0	0%
Pulmonology	23	8	35%
Radiology	166	56	34%
Rheumatology	3	1	33%
Sleep Studies	5	0	0%
Orthotics/Ped-orthotics	8	0	0%
Urology	51	11	22%
Vascular surgery	2	0	0%
Wound Care	5	1	20%
Total	**761**	**245**	**32%**

Of the missed appointments, 29 were due to refusals by 22 individuals. Eleven of 22

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(50%) were subsequently completed on follow-up appointments. Two remained pending for future appointments, and one follow-up appointment was no longer considered needed by the specialist. The 216 (245-29) remaining missed appointments for non-refusals involved 130 individuals. There were 91 follow-up appointments completed. Other follow-up appointments were pending or were not pursued for several reasons, including lack of guardian consent, the individual no longer needing the appointment, move to community, death, no longer clinically indicated, etc. For all missed appointments (refused and non-refusals), 35 specialty appointments remained outstanding.

The Medical Department had begun to communicate via email to other departments concerning cancelled appointments so IDTs could begin to review the background information and cause leading to the cancellation. This began to occur on 6/26/13.

On site, several specialty clinics were held to meet the needs of the individuals from October 2012 through May 2013. Onsite clinics occurred on the following dates:

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Endocrinology	10/31/12	25	23
	11/29/12	26	24
	12/20/12	17	10
	1/30/13	24	21
Inclement weather/record review only	2/26/13	18	0
	3/28/13	20	16
Total		**130**	**94 (72%)**

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Gynecology	12/5/12	13	13
	4/3/13	7	6
Total		**20**	**19 (95%)**

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Neurology/Epileptology	12/28/12	9	8
	1/25/13	11	11
	3/8/13	13	10

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			4/19/13	10	7	
			4/26/13	11	4	
		Total		**54**	**40 (74%)**	

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Neurology	10/24/12	14	12
	11/28/12	14	14
	12/12/12	13	11
	1/9/13	13	11
	1/23/13	11	11
	2/13/13	14	7
	2/27/13	9	8
	3/20/13	10	8
	3/27/13	11	10
	4/24/13	14	12
	5/15/13	14	13
Total		**137**	**117 (85%)**

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Podiatry	11/21/12	14	14
	12/19/12	14	9
	1/23/13	14	11
	2/20/13	13	13
	3/27/13	11	9
	4/17/13	13	11
	5/22/13	15	13
Total		**94**	**80 (85%)**

Specialty	Date of Clinic	Appointments Scheduled	Appointments Completed
Vision	10/5/12	13	9
	10/12/12	22	18
	11/2/12	11	8
	12/7/12	13	12
	1/4/13	18	16
	2/1/13	12	9
	3/15/13	21	17

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	4/5/13	19	18
Total		**129**	**107 (83%)**
On-campus total		**564**	**457 (81%)**

The Medical Department calculated that there were 90 individuals that had missed a clinic appointment and completed a follow-up. There was 100 percent follow-up completion for the two neurology clinics, the endocrinology clinic, and the gynecology clinic. Follow-up completion was 97 percent for podiatry, and 95 percent for vision clinic.

The above tables indicated that there were 107 individuals that missed a clinic appointment. Follow-up completed appointments agreed with the Medical Department analysis for the two neurology clinics and the gynecology clinic. For the other clinics, the information was not equivalent and rate of completion could not be determined.

The Facility was asked to submit copies of ISPAs for missed appointments or refusals for the past three months for mammograms, colonoscopies, and consultation appointments, both on-site and off-site. Copies of seven ISPAs were submitted. These included appointments for one or more procedures [e.g., barium enema, vagal nerve stimulator (VNS) placement, DEXA scan, CT scan of chest, mammogram, MRI, or cardiology appointment].

For two individuals, orders leading up to the appointment were not carried out (e.g., sedation, and bowel preparation). For one individual, the testing site needed assistance with a three-person transfer. One individual had been hospitalized during the time of the appointment. For one individual, the appointment was not missed, and the reason for including this was not clear. It was not clear if there were no other ISPAs created and implemented for missed/refused appointments or whether this was a sample of the ISPAs completed.

The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections 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>
Based on review of the sample of records:

- Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in six out of six (100%) records reviewed.

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		▪ Preventive care flow sheets were up-to-date in four out of six (67%) records reviewed. ▪ Current vision screening was documented within the prior 12 months in five out of six (83%) of the records reviewed, and in six of six (100%) within the prior 24 months. ▪ Audiological screening in the prior three years was recorded in the submitted documents in two of six (33%) records reviewed. For one of these two, the information was not located in the preventive care flow sheet, but was located in the ISP. For another individual, there was no information concerning an audiological screen, and the documents provided inconsistent information. For this individual, the annual medical assessment documented the individual responded to conversation and hearing was considered adequate, but the developmental history noted the individual was deaf. ▪ The influenza vaccination had been given to six of six individuals (100%) in a timely manner during 2012. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date and immunity status), and whether it was given if indicated, was recorded in six of the six (100%) active records reviewed. ▪ Whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or was being tracked for completion), was recorded in six of the six (100%) active records reviewed. ▪ A Tdap had been given to three of six (50%) individuals. For three individuals, although the most recent vaccination for tetanus was listed, it could not be determined if it was Tdap. It is recommended that the Infection Control Nurse and Medical Director review the recording of this vaccination to ensure accuracy and to prevent misinterpretation concerning which vaccination was provided. ▪ A pneumococcal vaccination had been given to six of six (100%) individuals. ▪ There was one individual age 60 or older and this individual received the zoster vaccine. *Mammograms* 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 39 women were identified as being between the ages of 40 and 70. The DADS SSLCs' policy "Preventive Health Care Guidelines," dated 8/30/11, was to be followed. Of these 39 women, 14 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, risk outweighs benefit, hospice case, etc.). Of the remaining 25 women, 23 had mammograms within the prior year. This was a compliance rate of 23 out of 25 (92%).	

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		From the sample of six medical records reviews, there were two females between the ages of 40 and 70. Of these, two females were eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Two of two (100%) were up-to-date on mammogram testing. *Pelvic exams/pap smears* A list of all females age 21 to 65 was provided. The list included 48 individuals and the dates of their last pap smears. Six individuals were noted to have had a hysterectomy. The reasons varied and for three individuals, the reason for the hysterectomy was listed as unknown. Those with hysterectomy were deleted from the total of 48, leaving 42 individuals recommended for pelvic exams and pap smears. Thirty-eight of 42 (90%) were current in pap smear evaluations and three were overdue. For one, the prior pap smear report indicated inadequate specimen, and no further information was submitted so the PCP could determine interpretation and possible next steps. From the sample of six active records reviewed, there were two females between the ages of 21 and 65. Two of two (100%) females were current on pap smear testing. *Colonoscopies* The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy and the reason for the colonoscopy. A total of 94 names were submitted. Of these, two were over the age of 75, and for zero there was incomplete data or data entry irregularities which could not be further included in the data. Of these, seven had clinical contraindications or family/guardian refusals of consent. Seven were at age 50 and were not counted due to the time for consultation, scheduling, and completion of the procedure. For those aged 51 and above, completion of a colonoscopy was expected. Therefore, the eligible population included 78 individuals. Of these, 72 completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. This was a compliance rate of 92 percent. Of the six active records reviewed, there were three individuals from the age of 50 to 75. Zero were over the age of 75. Three of three (100%) individuals had a colonoscopy completed in the past 10 years. For one individual, polyps were found and a repeat colonoscopy was recommended in two years from the original colonoscopy, but was not scheduled and completed until five years from the original colonoscopy. *Osteoporosis/Osteopenia prevention and treatment* 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	

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		and copies of the most recent DEXA scan reports were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T scores are indicated at intervals (i.e., every two to three years) to determine effectiveness of treatment. The following calculations were based on submitted data: ▪ A total of 118 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. Sixty-three had osteoporosis and 55 had osteopenia. ▪ Sixty-three of the 63 (100%) DEXA scans were considered current (completed within the prior three years). ▪ Sixty-two of 63 (98%) were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. ▪ Fifty-nine of 63 (94%) were treated with calcium supplementation. ▪ Sixty of 63 (95%) were treated with Vitamin D supplementation. ▪ Of the 55 with osteopenia, 55 of the 55 (100%) DEXA scans were considered current (i.e., completed within the prior three years). ▪ Forty-nine of 55 (89%) were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. ▪ Fifty-five of 55 (100%) were treated with calcium supplementation. ▪ Forty-eight of 55 (87%) were treated with Vitamin D supplementation. A dietary calculation of calcium intake was included in most of these cases. However, although dietary intake, multivitamin when calcium was an ingredient, and calcium supplementation were often listed, there was no calculation of total calcium intake to guide the PCP in determining the amount of calcium supplementation that was needed, if any. In some cases, it appeared there might have been excessive calcium intake. The total intake of Vitamin D from dietary sources, multivitamins, and supplements was also not provided. A total amount would assist the PCP in prescribing the appropriate amount of Vitamin D. In its response to the draft report, the State indicated this information was available. However, it did not provide the information due to a misunderstanding about the Monitoring Team's document request. Additionally, a record review, including review of dosages and types of medications to prevent progression from osteopenia to osteoporosis is recommended to ensure optimal preventive treatment, as there are many variables to consider. It is recommended that national professional guidelines for this clinical area be followed. The medical and pharmacy staff would benefit from periodic in-services focusing on updated changes in clinical prevention and treatment guidelines for osteoporosis as they occur. From the sample of six medical records reviewed, five had a diagnosis of osteopenia or	

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		osteoporosis. ▪ Five of six had completed a DEXA scan. ▪ Four of five (80%) with a diagnosis of osteopenia or osteoporosis had a DEXA scan completed in the prior three years. For one of five, attempts were made but the skeletal abnormalities would not allow accurate test completion. This individual was assumed to have osteoporosis. ▪ Of the remaining four, four (100%) had a DEXA scan/T score recorded. ▪ Of these, four of four (100%) with DEXA scan results had a T score consistent with the diagnosis of osteoporosis or osteopenia. For one, the individual was diagnosed with osteopenia, although the T score was stated as 1.7. Other documents were not submitted to clarify the reading. For this individual, the annual medical assessment indicated the T score was 1.7 (which indicates no osteopenia or osteoporosis). The preventive care flow sheet only listed the date of the DEXA without a confirmatory score. The IRRF also did not state the T score, listing only the date of the DEXA. As the actual DEXA scan was completed over a year ago, it was not available for review in the requested documents. In its response to the draft report, the State indicated that the actual reading was negative (-) 1.7, which was interpreted as osteopenia. This would indicate that the annual medical assessment was in error either as a dictation or transcription error. However, if the individual had a T score of -1.7, this brought up an additional problem. Specifically, that the individual was also not named in the submitted lists of those with osteopenia or osteoporosis was problematic. If the individual had osteopenia, the submitted list should have included the name. This indicated that the database for osteopenia was not a complete or accurate list. It is recommended that the contents of the annual medical assessments be reviewed for quality and accuracy through an internal QA medical department monitoring process. It is also recommended that the actual score of the DEXA scan be recorded in various places of the active record (preventive care flow sheet, IRRF, etc.) rather than only the date of the test, as that may have identified the inconsistency, the need for a review of the T score and the need to correct the annual medical assessment. It is recommended that the database for osteopenia and osteoporosis be reviewed to determine the process for identifying those individuals placed on the list. Databases need to be complete and accurate in order for analysis to be meaningful. ▪ Of these five with a diagnosis of osteopenia or osteoporosis, three (60%) had been prescribed supplemental calcium. ▪ Of these five with a diagnosis of osteopenia or osteoporosis, five (100%) had been prescribed a supplemental Vitamin D equivalent, and three (60%) had a bisphosphonate ordered. ▪ Of these, one (20%) had Miacalcin prescribed. ▪ For one individual, from the submitted documents, it could not be determined	

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		which medication was currently prescribed (i.e., Prolia or Miacalcin or both). *Down syndrome and hypothyroidism* 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 thyroid test completed within the prior 12 months. <u>Acute and Emergency Care</u> *Emergency Room Visits and Hospitalizations* The active record was reviewed for nine individuals who had most recently gone to the ER and returned. One individual had two ER visits, resulting in review of 10 ER visits. The following summarizes the results of this review: ▪ Information was submitted for six of 10 (60%) records indicating that the ER was provided appropriate medical background information prior to the arrival of the individual. ▪ Prior to the transfer to the ER, a PCP was on-site for three of these transfers. o In three of three (100%) records, the PCP had written an IPN that included the date and time. o For three of three (100%) PCP transfer IPNs, vital signs were recorded. o For three of three (100%) PCP transfer IPNs, reason for the transfer was documented. o In three of three (100%), the SOAP format was utilized in completing the PCP IPN concerning transfer. ▪ A copy of the ER report was available in 10 of 10 (100%). ▪ Of the 10 ER visits, diagnostic categories included: trauma (five cases), complications of a feeding-tube (three cases), and respiratory concerns (two cases). ▪ When the individual returned to the Facility after evaluation at the ER, 10 of the 10 (100%) active records had a PCP IPN. o Ten of 10 (100%) post ER visit PCP IPNs included date and time. o Eight of 10 (80%) post ER visit PCP IPNs included a record of vital signs. o Ten of 10 (100%) post ER visit PCP IPNs utilized a SOAP format. o A summary of ER information and findings was included in 10 of 10 (100%) PCP IPNs. ▪ For nine of 10 (90%), there was sufficient information submitted to indicate the treatment was considered timely. There might have been delay in care in recognizing/discovering the concern for one individual prior to transfer to the ER (i.e., Individual #223). Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review:	

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		▪ Eight individuals returned to the Facility after 10 hospitalizations. ▪ Zero individuals died while in the hospital. ▪ Ten of 10 (100%) had PCP IPNs post hospitalization. o Of the 10 post hospital PCP IPNs submitted, eight (80%) included vital signs. o Ten of 10 (100%) post hospital PCP IPNs included date and time. o Ten of 10 (100%) post hospital PCP IPNs had an adequate summary of hospital events and findings. o Ten of 10 (100%) post hospital PCP IPNs used the SOAP format. ▪ Nine of 10 (90%) active records of the hospitalized individuals included a copy of the hospital admission history and physical. ▪ Eight of 10 (80%) active records included a copy of the hospital discharge summary. ▪ Nine of 10 (90%) active records included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ Ten of 10 (100%) included Hospital Liaison Nurse notes for the individuals. ▪ Additional PCP IPN notes were indicated for nine of the hospitalizations. o For seven of the nine (78%) individuals that returned to the Facility, additional PCP IPNs were included as part of the follow-up. ▪ Of the 10 hospitalizations, major organ system categories included the following: respiratory concerns (six), neurological concerns (one), gastrointestinal concerns (two), and metabolic concerns (one). The Facility did not have an Infirmary. It was noted that when an individual returned from the hospital, the individual was admitted to Quail until cleared by the PCP for return to the individual's residence. The Facility submitted information listing individuals that presented to the ER, entitled: "ER visits, from May 1, 2012 to May 31, 2013." From this report, the numbers of ER visits per month were tabulated from November 1, 2012 through May 31, 2013. The numbers listed per month were as follows: ▪ November 2012 - seven ER visits; ▪ December 2012 - 12 ER visits; ▪ January 2013 - 11 ER visits; ▪ February 2013 - 13 ER visits; ▪ March 2013 - eight ER visits; ▪ April 2013 - nine ER visits; and ▪ May 2013 – six ER visits. This data was similar to the data provided by the Medical Department. The Medical Department provided a document entitled "ER Data 4th Quarter (Calendar Year) 2012," in	

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		which there were eight ER visits in November 2012 and 12 ER visits in December 2012. The Medical Department provided a document entitled "ER Data1st Quarter (Calendar Year) 2013," in which there were 10 ER visits in January 2013, 13 ER visits in February 2013, and eight ER visits in March 2013. According to the information provided, reasons for the ER visit were categorized according to body system and chief complaint: ▪ Trauma - eight visits; ▪ Respiratory disease - 11 visits; ▪ Gastroenterology concerns - 32 visits; ▪ Genitourinary concerns – two visits; ▪ Behavioral issues - one visit; ▪ Infectious disease – one visit; ▪ Endocrine disease – zero visits; ▪ Orthopedics - three visits; ▪ Neurological disease – nine visits; and ▪ Cardiovascular disease – one visit. The Facility submitted information, listing individuals that were admitted to the hospital, entitled "Hospital Visits, from May 1, 2012 to May 31, 2013." From this report, the numbers of hospitalizations, per month, were tabulated from November 1, 2012 through May 31, 2013. The numbers listed per month were as follows: ▪ November 2012 - eight hospital admissions; ▪ December 2012 - 12 hospital admissions; ▪ January 2013 - six hospital admissions; ▪ February 2013 - six hospital admissions; ▪ March 2013 - five hospital admissions; ▪ April 2013 - seven hospital admissions; and ▪ May 2013 - nine hospital admissions. This data agreed with the Medical Department document entitled: "Hospital Data 4th Quarter (calendar Year) 2012," which listed eight hospital admissions for November 2012 and 12 hospital admissions for December 2012. The Medical Department document entitled: "Hospital Data 1st Quarter (Calendar Year) 2013" listed six hospital admissions for January 2013, six hospital admissions for February 2013, and five hospital admissions for March 2013. Reasons for the hospitalization were categorized according to body system and chief complaint, according to the information provided: ▪ Trauma - zero hospital admissions ▪ Respiratory disease - 25 hospital admissions	

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		▪ Gastroenterology concerns - 13 hospital admissions ▪ Genitourinary concerns - five hospital admissions ▪ Orthopedics – zero hospital admissions ▪ Neurological disease - two hospital admissions ▪ Cardiovascular disease - six hospital admissions ▪ Metabolic concerns – two hospital admissions *Pneumonia* Data was submitted that had been entered into the Avatar database. Information concerning pneumonias was submitted for the time period from November 15, 2012 through May 15, 2013. According to this database, entitled "Pneumonia Profile Report from November 15, 2012 to May 15, 2013," there were 16 pneumonias during this time period. Of these 16, three were categorized as aspiration pneumonia. Off-site physicians diagnosed three of these three aspiration pneumonias. Nine were diagnosed with healthcare associated pneumonia. Four were diagnosed with pneumonia, but with no further descriptor. One individual was listed as having pneumonia, but the information did not provide evidence of pneumonia, and was not further reviewed. For the 16 individuals with a diagnosis of pneumonia, the location at the time of the diagnosis was the hospital for 13, and LBSSLC for three. As part of confirmation of the diagnosis of pneumonia, the following information was provided in this database: six were documented to have had a chest x-ray completed; six were noted to have an enteral feeding-tube prior to the onset of pneumonia (one received a PEG-tube during the hospitalization for pneumonia), but only two of nine had information concerning food texture and fluid thickening provided; and three of six, that were tube fed, recorded whether the feeding formula rate of administration was bolus, intermittent or continuous. Further information was not consistently provided, and represented a decrease in the completeness of the information entered into the database compared to data submitted during the Monitoring Team's prior visits. From this Avatar database, the occurrence of pneumonias per month were as follows:	

Month	Aspiration Pneumonia	Health Care Acquired Pneumonia	Pneumonia Not Otherwise Specified
November 2012	1	1	0
December 2012	1	4	2
January 2013	1	1	0
February 2013	0	3	0
March 2013	0	0	0
April 2013	0	1	1
Total = 16	**3**	**10**	**3**

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Total December to April = 14	**2**	**9**	**3**

There was important information not included in the submitted document. It was not clear whether the original document could be expanded to reveal additional information in drop down boxes or toggles, etc. Additionally, the numbers per month did not agree with other databases for pneumonia. The database should be reviewed for accuracy and completeness to ensure it has value in guiding the Medical Department in further action steps in preventing and treating pneumonia.

A document (untitled) provided a response to the requested information: "For those with diagnosis of pneumonia in last six months and taking food/fluid by mouth, type of liquid, and type of texture of solid food ordered, and last swallow study." This document did not list the time frame of the six months. Seventeen individuals were listed with pneumonia. Seven individuals had a G-tube and were Nothing by Mouth (NPO) status, two had a jejunostomy tube and were NPO, and one had a G-tube and received pleasure feedings by mouth (PO). All others received a therapeutic diet with specific texture of solid food and/or specific thickening of fluid.

From a report entitled: "LbSSLC Infection type by month report (report date 12/1/12-5/31/13)," the following information was noted:

Month	Pneumonia	Aspiration Pneumonia	Health Care Associated Pneumonia
December 2012	0	3	5
January 2013	0	1	0
February 2013	0	1	1
March 2013	0	0	0
April 2013	0	0	0
May 2013	3	1	1
Total = 16	**3**	**6**	**7**
Total December to April = 11	**0**	**5**	**6**

From a third submitted document entitled "Absolute numbers of new cases for pneumonia, date range May 1, 2012 – May 29, 2013," the following numbers of pneumonia cases were reported per month:

- December 2012 – six;
- January 2013 – two;

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		▪ February 2013 – three; ▪ March 2013 – zero; ▪ April 2013 – three; ▪ May 2013 – five; and ▪ **Total: 19 Total December to April: 14** Six individuals were diagnosed with sepsis from 10/1/12 to 5/22/13. The Facility reported that four individuals had acute choking spells requiring an abdominal thrust maneuver from October 2012 through May 2013. None required treatment in the ER. *Trauma* A document was submitted, untitled and undated, listing three fractures that occurred in the prior six months. Two fractures were listed as occurring in February 2013, and one fracture occurred in April 2013. Anatomic location of the fracture included: foot, humerus, and wrist. All were sustained in the residential environment. One was a complication of a seizure, and one was due to being pushed by a peer. During the time period from November 15, 2012 through May 15, 2013, seven individuals went to the ER for injuries. The submitted information listed one additional individual that was hospitalized, and an incidental finding on a CT scan indicated an injury had occurred. <u>Clinical pathways</u> The six medical record reviews included an evaluation to determine whether the evaluation and treatment of GERD and osteoporosis was consistent with the Facility clinical guidelines/pathway and/or national professional standards. These are found in the sections reviewing these diagnostic categories. <u>Chronic Conditions and Specific Diagnostic Categories</u> *At-Risk Individuals* Based on a review of the six individuals in the sample, two of six (33%) included an adequate medical assessment to assist the team in developing an appropriate plan. The following are examples of clinical questions and concerns related to the quality of the assessments completed, outstanding concerns for which there was no information available in the submitted documents, and at times, inability to follow the clinical rationale in determining assessments and treatment options. Consistency and accuracy of information was also problematic in one of six records reviewed: ▪ Individual #283 had been hospitalized three times from November 2012 through March 2013. Diagnoses provided included septic shock, aspiration	

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		pneumonia, and GERD for the first hospital admission; health care associated pneumonia and C. difficile colitis for the second hospitalization; followed by a return to the hospital one day after being discharged with bibasilar pneumonia for the third hospitalization. The individual required ventilator support during these hospitalizations. The individual had a gastrostomy tube (G-tube) placed in 2008, and had been treated medically for GERD, as well as with head of bed elevation. The individual received oral suctioning during tooth brushing. Of note, the individual was considered under ideal weight range, and had lost 30 percent of the individual's weight since April 2012. In response, the feeding rate had been increased since then to provide more nourishment and the individual was followed by the dietitian. The individual developed a stage two decubitus after the March 2013 hospitalization and the decubitus had healed by April 2013. There appeared to be a lack of information concerning further gastrointestinal work-up. Based on the submitted documents, there appeared to be no further consideration of whether GERD was a significant contributor to the aspiration pneumonia (i.e., was GERD worsening and contributing to pulmonary concerns), and there was no information to determine if this had been further evaluated as a cause for the individual's respiratory problems. Prior to these hospitalizations, the individual had an esophagogastroduodenoscopy (EGD) in 2011, which found a hiatal hernia. There was no test or test results indicating the severity of reflux. Since the more recent repeated pneumonias, there was no current evaluation to determine the presence or severity of reflux as a contributing comorbid condition. Considering the severity of the respiratory illness requiring ventilator support, ruling out worsening GERD might be an important step and might prevent recurrence if found to be a significant comorbid condition. Gastroparesis was also a concern, which did not appear to be evaluated. Increasing the feeding G-tube rate with gastroparesis and/or GERD might exacerbate the pulmonary concerns. If GERD or gastroparesis were contributing to reflux aspiration, then additional treatment options might need to be considered, including surgical options for severe GERD. A pulmonary consult of 2010 indicated the individual's continued risk of aspiration of saliva would require surgical intervention to reduce the risk. It was not clear from the documents if such intervention, with significant risks and benefits, was discussed with the IDT or the family/guardian, nor if there was documentation of discussion. If there had been discussion or decision, it was not in any submitted documents. If there was a family/guardian meeting concerning surgical options for the aspiration, it would be beneficial to ensure this remained available in the plan of care section of the annual medical assessment.	

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		The impact of environmental factors on the repeated respiratory distress did not appear to be reviewed. At the time of the ISP, the weight loss was treated with additional nutrition, and was believed due to the prior illness and hospitalizations. However, there did not appear to be any discussion in the IRRF concerning other potential causes of weight loss, no further assessments ordered, nor plans for further aggressive evaluation if further weight loss were to occur. In summary, it was difficult to track the completeness of assessments in resolving and preventing further repeated pneumonias. For an individual with repeated severe acute illness, there appeared to be significant gaps in assessment and whether more aggressive treatment options were indicated could not be determined. Additionally, there was little assessment of the significant weight loss, other than assuming it was due to hospitalizations. A plan was lacking for aggressive work-up should the weight loss or lack of weight gain continue despite increased nutrition. ▪ Individual #114 was hospitalized three times from November 2012 through January 2013. For the first hospitalization, the individual had hypoxia and lethargy, and it was believed the individual was postictal. The second hospitalization was for a health care associated pneumonia. The third hospitalization was for respiratory distress, bacteremia, and a urinary tract infection (UTI). The individual had a G-tube, and was known to silently aspirate nectar and honey thick liquids. The individual was nothing by mouth (NPO), but the IRRF also indicated that the SLP was following the individual with pleasure feedings of pureed food and honey thick liquids. The SLP documents were not reviewed to determine goals, risks, and benefits based upon known silent aspiration of honey thick liquids, or to determine if the SLP had implemented a program. The individual had severe gastroparesis from a June 2011 study. The feeding formula rate was intermittent. There was medication prescribed for the gastroparesis, and there was noted to be minimal gastric residuals at the time of feeding formula administration. There was a history of GERD, but the severity of the GERD did not appear to have been evaluated, based on submitted documents, to determine the severity of reflux as a contributing cause to aspiration, nor whether the intermittent feeding was refluxing due to GERD and gastroparesis. There appeared to be the need for further review of the individual's high-risk conditions in order to ensure appropriate treatment. ▪ Individual #284 had a long history of pica, requiring hospitalization and endoscopy in January 2013 to remove three gloves. There were numerous pica attempts in the past. The Level of Supervision (LOS), according to the 4/17/13 ISPA, was enhanced at all times until asleep, and then 15-minute bed checks. The ISPA also stated that when there were three consecutive months in which there were no incidents of pica attempts or food foraging, the LOS would be reduced. Several staff were involved in pica sweeps and home monitoring each	

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		shift. There had been a liberalizing of the individual's diet to include increased caloric intake with snacks and liquid supplement. Despite the current LOS, the individual drank hand sanitizer on 5/5/13. There was no information concerning whether Facility Administration would be involved with the final decision process before reducing the LOS. Given the long history of pica and numerous incidents of ingestion of dangerous items (i.e., gloves that could result in death), there was no clear rationale documented to begin to reduce LOS based on less food foraging or pica attempts over a three-month period of time. It would be important for the IDT to review the LOS in place at the time of the prior pica attempts and events, and the length of time without a restricted LOS before a pica event occurred. As this individual had a long history of pica, the IDT needed to have a clear rationale written as to the reason for expecting the habit/behavior to remain resolved once the LOS was removed or reduced. With adequate LOS, the data might indicate the LOS worked, rather than the risk of pica had disappeared. Removing a successful plan, which included adequate LOS as a component potentially would place the individual at risk. Additionally, the current LOS might be inadequate due to the individual's ingestion of the hand sanitizer. ▪ Individual #139 had several challenging health conditions. This individual was hospitalized on 3/1/12 for hypoxia, UTI, aspiration pneumonia, and electrolyte imbalance; on 3/25/12 for vomiting and GERD; on 11/18/12 for asthma exacerbation and UTI; and on 6/20/13 for a health care associated pneumonia and sepsis with electrolyte imbalance. The individual was fed in an upright position, and remained upright for one hour after feeding. Oral care suctioning was provided. There was a diagnosis of restrictive lung disease and allergic rhinitis, and the individual intermittently required albuterol nebulizer treatments, and other medication as well as periodic oxygen (O2). Attention to head elevation while bathing was included in the physical and nutritional management plan (PNMP). The individual was tube fed and residuals were documented prior to formula feeding administration. The individual had a suprapubic catheter and a nursing protocol was identified for this. The individual had osteoporosis, and was given Miacalcin and Vitamin D, according to submitted information. Given the complexities of this individual's case, an endocrinology consult for alternative osteoporosis treatment might be indicated. The PCP did not attend all ISPAs with a medical focus, and the risk ratings needed further review. For instance, the IDT determined the individual was at low risk for fluid imbalance, yet the individual had two hospital admissions in which electrolyte abnormalities were found. The individual was considered low risk for infection, yet had risk of UTIs with the suprapubic catheter, and had a history of C. difficile infection in May 2013. The 5/16/13 ISPA did not address change in risk status for infection. The hospitalization for asthma exacerbation	

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		did not appear to be followed by a review of the environment for allergens (i.e., cleanliness of vents, location of bed near air conditioning units, housekeeping cleaning supplies, etc.), or review by the Respiratory Therapist concerning additional therapeutic options. The Active Problem List did not appear complete (e.g., the suprapubic catheter was listed under inactive problems), and neurogenic bladder, C. difficile infection, and asthma were not listed. The IDT depends on accurate, complete information in developing the IRRF, and the PCPs should ensure these lists are updated at intervals. *GERD* As part of the review of six records, GERD was reviewed. ▪ Of the six individuals, five were diagnosed with GERD and one with gastritis. ▪ For five of six, an appropriate medication was prescribed. For one individual, the diagnosis was listed from 2008, but was subsequently listed as low risk and not treated. ▪ Four of the six had a feeding-tube. ▪ Four of six (67%) had appropriate timely evaluation completed. ▪ For two of six, the impact of the GERD on respiratory distress, aspiration, and aspiration pneumonia was not evaluated. *Tracheostomies* Five individuals currently had tracheostomies. *Newly diagnosed Chronic Conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. No individual was newly diagnosed with diabetes mellitus type I or II. Two individuals were newly diagnosed with cardiovascular disease. One individual was diagnosed with a myocardial infarction in April 2013, and one individual was diagnosed with hypertension in March 2013. One case of a newly diagnosed cancer was reported in the past year. On January 15, 2013, an individual underwent a wide local incision for a multifocal basal cell carcinoma. *Pica* A log of pica incidents was submitted, but it was dated 3/15/13. Nine individuals each had one incident of pica from November 2012 through March 15, 2013. It listed two incidents in November 2012, one incident in December 2012, three incidents in January 2013, and two incidents in February 2013. Hospitalization for pica occurred in January 2013 for one individual. For these nine individuals, a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR) diagnosis of pica was documented for six of nine (67%). The diagnosis of pica was listed in the active problem list for six individuals. Pica was listed as a targeted behavior in the BSP for eight of nine	

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		(89%) individuals. Items ingested included: coins, metallic nuts, screws, pebbles, cigarette butts, small sticks, paper and paper cups, disposable gloves, bed sheets, T-shirts, Styrofoam, rubber bands, plastic bags, and food wrappers. *Chronic Constipation* A document was submitted entitled: "List of individuals who have a diagnosis of constipation or are receiving anti-constipation medication at least weekly." This document was undated, but was scanned 6/4/13. This list included 141 individuals. From a document entitled "Absolute numbers of new cases for bowel obstructions. Date Range: May 1, 2012 - May 30, 2013," information was categorized according to the diagnosis of bowel obstruction, fecal impaction, and ileus. From November 1, 2012 through May 2013, there were two new cases of bowel obstruction (one in November 2012 and one in December 2012), four new cases of fecal impaction (one in November 2012, two in January 2013, and one in April 2013), and one new case of ileus (in May 2013). This list did not specifically address bowel perforation. A separate document, which was untitled, indicated there was one death with an autopsy finding of bowel perforation in December 2012. There was a second bowel obstruction noted from December 2012. This document provided different information compared to the prior information indicating one bowel obstruction in November 2012, and one bowel obstruction in December 2012. *Enteral Feeding-Tubes* The Facility submitted information that four individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes. A review of the medication profiles was completed to determine whether medications not recommended for administration through these specific tubes were ordered through the tubes (e.g., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for zero of four (0%) individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were <u>not</u> prescribed. All involved used of a quinolone. Although the detailed medical history was not included, there appeared to be one or more individuals with both a G-tube port and a J-tube port, according to some orders. For these individuals, at times the quinolone was ordered through a G-tube and at times through a J-tube. Most orders occurred in 2012, although for one individual, the date of administration was 1/3/13 through 1/10/13. Additionally, there was one order for Sucralfate through a J-tube for one of these four individuals, for dates of 1/20/12 through 5/1/12. Renewal of the order thereafter was through a G-tube. The Medical Department might need to review these orders with Pharmacy to determine the accuracy of the route in the submitted documents, and whether there was a patient intervention form and communication addressing these issues.	

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		Skin Integrity The Skin Integrity Committee met October 26, 2012, and January 13, 2013. Minutes were submitted for both meetings. In the October 26, 2012 meeting minutes, two pressure ulcers were documented and one skin integrity concern that required further information. Both decubiti were categorized as Stage II. The January 13, 2013 meeting minutes did not provide any follow-up information for these two pressure ulcers, nor indicate whether any additional pressure ulcer had occurred from the last meeting. It appeared the focus of the meetings was educational, as the committee members participated in a webinar or video concerning pressure ulcers. A document entitled "Absolute numbers of new cases for: Decubitus," with scan date of 6/17/13, listed two new pressure ulcers in November 2012, one new pressure ulcer in February 2013, and two new pressure ulcers in March 2013. At the time of the Monitoring Team's visit, there was one pressure ulcer for an individual on the campus, which dated from March 2013. *Other Conditions* Mention is made of the C. difficile infections from January 2013 through May 2013, reported in the "LbSSLC Infection Type by Month Report, Report date: 12/1/12-5/31/13." The following indicates the numbers of infection per month reported: December 2012 - one, January 2013 - 16, February 2013 - 16, March 2013 - 14, April 2013 - 13, and May 2013 - seven. This was a total of 34 infections reported in these two calendar quarters. These occurred in the following residences: 504 East Mesquite Drive, 504 West Mesquite Drive, 513 South Cedar Avenue, 517 South Cedar Avenue, 525 North Cedar Avenue, 527 North Cedar Avenue, and 528 North Cedar Avenue. The 504 East and 504 West Mesquite Drive reported the highest numbers of C. difficile infections. It appeared the rate of infection had decreased since a peak in March and April 2013. It was not clear whether the infection control nurse had provided the Facility administration with a report summarizing the recent history of this infection at LBSSLC, especially origin (i.e., hospital versus ER visit versus LBSSLC versus other site), adequacy of treatment, preventive steps taken, adequacy of preventive steps from December 2012 and changes/additions of preventive steps since that time, as well as what additional steps would be taken at LBSSLC in the future should the rate of infection increase (i.e., what has been learned and what additional steps are applicable at LBSSLC). *Seizure Management* A list was submitted indicating that approximately 129 individuals had a diagnosis of a seizure disorder, as of May 6, 2013 (scan date of document). Thirty individuals had a diagnosis of a seizure disorder, but were not currently prescribed anti-epileptic medication.	

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		The Facility submitted information concerning antiepileptic medication usage. From a document entitled "Seizure Date," which was undated, but had a scan date of 6/4/13, 99 individuals were prescribed antiepileptic medication. ▪ Forty-one (41%) were prescribed one antiepileptic medication. ▪ Twenty-nine (29%) were prescribed two antiepileptic medications. ▪ Seventeen (17%) were prescribed three antiepileptic medications. ▪ Nine (9%) were prescribed four antiepileptic medications. ▪ Three (3%) were prescribed five antiepileptic medications. Five individuals were considered to have a refractory seizure disorder. All five of these had a VNS implant. There was one individual who was currently being evaluated for a VNS. In the prior six months, five individuals went to the ER for uncontrolled/prolonged or repetitive/new onset seizures. One individual was referred twice to the ER. Three ER visits were made for acute seizure control and evaluation in April 2013. Two ER visits were made for acute seizure control and evaluation in May 2013, and one visit occurred in June 2013. No individuals were diagnosed with status epilepticus. A list was submitted indicating the percentage of treated individuals that were prescribed older antiepileptic medications. A total of 36 (36%) of individuals prescribed antiepileptic medication were prescribed Dilantin, four (4%) were prescribed Primidone, 12 (12%) were prescribed Phenobarbital, and zero (0%) were prescribed Felbamate. Additionally, six individuals currently had a VNS implant. Of those with VNS placement, date of placement ranged from 2003 to 2012. For one individual, date of VNS placement was "not known." For one individual, the VNS "was not being used." For another individual, a VNS battery was not replaced per legal guardian decision. Of the six VNS placements, four appeared to be operational. The Facility submitted neurology consultation notes documenting seizure management for five individuals. The following provides a summary of the review of these records: ▪ Five of the five (100%) individuals had been seen more than once over the past year. ▪ One of these individuals did not have a confirmed seizure disorder and was not further included in this data. ▪ For the four individuals, there were 13 neurology visits. o For five of the 11 (45%) visits in which the individual had seizure activity since the prior appointment, the notes indicated a description of	

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		the seizures. o For 13 of the 13 (100%) visits, the notes documented frequency or date of seizures. o For 13 of the 13 (100%) visits, the notes included a review of current medications for seizures and dosages. o For 10 of the 13 (77%) visits, notes included recent blood levels of antiepileptic medications. o For 13 of the 13 (100%) visits, notes included recommendations. o For six of the 13 visits (46%), reference was made to the presence or not of side effects. As this document was submitted as a stand-alone document, similar to other consult visit reports, it remained difficult to track specific information. Although the record might have been available at the time of the consult and detailed information was available to the neurologist, it was not available for further review in the one submitted document. The preliminary consult request information had brief entries as to the reason for the consult, such as "follow-up seizures/increase in Keppra." However, consult requests often have other important information available in a succinct format. Comparable information would have included the number of seizures per month since the last Neurology consult, the type of seizure activity, current medications and dosages, observation of side effects (e.g., lethargy, tremor, etc.), as well as lab values for the most recent levels with dates of levels. It is recommended that this information be extracted and summarized on the consult request form in the appropriate space to make the consult report more meaningful. <u>Do Not Resuscitate Orders</u> A total of 12 individuals at the Facility had DNR orders in place. The date of the original DNR was submitted in a document entitled "Do Not Resuscitate List," updated 4/17/13. DNR orders were initiated for three individuals in 2012, for one individual in 2011, for one individual in 2010, for three individuals in 2009, and for four individuals in years prior to 2009. For 12 of 12 (100%), adequate clinical justification was provided for the DNR. Clinical justification included the following: three individuals had dementia, four had compromised respiratory function (one on hospice), one had multiple organ system decline (on hospice), two had end stage renal disease, and two had cancer (one on hospice). The three individuals enrolled in hospice were resuscitative status III. The others were resuscitative status II. For further verification of qualifying condition and review by the Facility, the policy: "LBSSLC – Health Services: Planning End of Life Care" (dated 2/17/10) was reviewed. In	

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		the definition of terminal condition, the information includes: "An individual who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Texas Health and Safety Code, Chapter 142 is presumed to have a terminal condition." Additionally, the State indicated that a "DNR Policy is in draft form and cannot be released." The policy dated 2/17/10 was used in reviewing those individuals with DNR status. However, given that it has been pending for a while, the State is strongly encouraged to finalize the DNR policy. Additionally, the definition of Resuscitative Status II and III were provided in the policy. Resuscitative Status II was defined as "Therapeutic effort with no heroics - intervention in which conservative therapeutic and supportive measures will be performed to reduce mortality and morbidity, excluding cardiac massage, defibrillation, surgical intervention, hyperalimentation, or implementation of other measures deemed extraordinary may be restricted or excluded. This category of intervention is designated only for an individual with a qualifying condition (use of oxygen, rescue breathing, and suctioning is acceptable, permissible and is expected to be initiated when the individual has a pulse but no respiratory effort is present or (aren't [sic]) unless specifically addressed on the form). Existing treatments and medical care will not necessarily be discontinued as a result of an individual being assigned a Category II Resuscitative status." For clarification, the earlier 8/7/09 DNR policy did not include the typographical error indicated by [sic] in the 2/17/10 policy. The word "apparent" in the 2009 policy was replaced by "aren't" in the most recent policy, which did not make sense. Resuscitative Status III was defined as "Palliative measures only - intervention with measures directed toward reducing or eliminating pain, if possible, and enhancing the comfort and dignity of the individual will be maintained. However, no resuscitative measures will be performed. This category of intervention is designated only for an individual with a qualifying condition." At the time of the Monitoring Team's visit, three individuals were currently enrolled with hospice. Of the nine other individuals with DNR status, the Facility was asked to submit ethics committee minutes discussing the DNRs. Four of the nine were submitted. However, the diagnoses listed for the five without evidence of an ethics committee meeting had terminal diagnoses (i.e., end stage renal disease, or Alzheimer's dementia). On review of submitted documents, there were two Facility Ethics Committee meetings (October 17, 2012 and December 18, 2012), to discuss DNR status, and one individual was discussed at each meeting: Minutes of the Facility Ethics Committee meetings included the following components:	

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		▪ The meeting minutes documented the date in two of two (100%) meetings. ▪ The meeting minutes documented time in one of two (50%) meetings. ▪ The meeting minutes included the name of the individual for discussion of DNR in two of two (100%) meetings. ▪ The meeting minutes listed names of attendees in two of two (100%) meetings. ▪ The meeting minutes included a signature sheet in one of two (50%) meetings. For one set of meeting minutes, there was also no reference to a signature sheet. ▪ The meeting minutes of one of two (50%) provided a synopsis of the medical history in the minutes. ▪ The meeting minutes of one of two (50%) did not include a synopsis of the medical history in the minutes but referenced an attachment, which was reviewed at the meeting, and provided the medical history and current status. This was not included in the submitted information. Because of this, the minutes of this meeting (October 17, 2012) was of limited quality and value. ▪ One of two (50%) meeting minutes, contained reference to an earlier IDT meeting, which included critical discussion with family/guardian, signing of the DNR paperwork, and the status of obtaining guardianship by the mother. A written document of the IDT meeting was not submitted which reduced the quality and value of the minutes of this meeting (October 17, 2012). ▪ The meeting minutes included discussion of the medical history and current condition by the PCP in one of two (50%). For one set of meeting minutes (October 17, 2012), there was no documentation of discussion by the PCP, because this apparently was located on a separate document (attachment not submitted). ▪ For two of two (100%), the meeting minutes included a recap with recommended action steps outlined. ▪ For two of two (100%), the meeting minutes included the qualifying condition/determining diagnosis. The State "Resuscitative Status II" and "Resuscitative III" forms indicated that the DNR decision had to be renewed at least annually, and that "failure to renew or to designate alternate resuscitative status results in Resuscitative Status I designation." A review of these documents for the 12 individuals indicated that nine had been updated in the prior 12 months. Three were outdated: for Individual #269, the document was last signed 10/3/11, and the last PCP order for renewal of DNR status was 1/17/12. For Individual #74, the DNR form was last signed 3/1/12. For individual #161, the DNR form was last signed 2/2/12. It is recommended that a monitoring system be created to ensure these forms are updated in a timely manner so as not to cause confusion about DNR status for these individuals. <u>Mock Code Drills and Emergency Response Systems</u>	

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		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> During the prior six months, the Facility completed one non-facility physician audit review (Round #7). The following represents a synopsis of the information: ▪ For the one external peer review dated February 7 to 8, 2013, PCP compliance in essential areas ranged from 82 to 90 percent. For areas considered non-essential, compliance ranged from 80 to 100 percent. ▪ The external audit review process information indicated the number of records chosen for review. Eleven records were reviewed using the Medical Provider Quality Assurance Audit (i.e., general medical audit). ▪ The external audit review process information indicated how the sample was obtained. The auditor exit information indicated: "charts were randomly chosen by the Facility's QA Department." ▪ Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? (5) Is the annual physical summary complete including past medical history, family history, and a plan of care? (9) Have the appropriate immunizations been given? (11) Is there documentation present for not providing preventive services? (16) Do the medication orders for acute conditions include indication and duration for all medications prescribed? (18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? (21) Is each of this person's progress notes and orders signed, dated, and timed? (22) Is the provider's documentation legible? (26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant? ▪ The Facility did not differentiate from external and internal medical peer review audits in generating corrective action plans. A total of 57 corrective action plans were created. ▪ An external medical management audit for Round #7 was also completed on February 7 to 8, 2013. The three areas of clinical focus were: aspiration pneumonia, diabetes mellitus, and osteoporosis. Nine records were reviewed for the Medical Management Audit. Three records were reviewed for each of these three diagnoses. Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: o Osteoporosis (4) Did the provider order or document findings of a Dental exam before initiating a bisphosphonate? o Aspiration pneumonia (3) Is there evidence that the individual has had	Noncompliance

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		a Modified Barium Swallow (MBS) completed since a diagnosis of aspiration pneumonia? (4) Did the provider order appropriate interventions after the MBS? (5) Did the provider order a GI consult or a pulmonary consult if indicated? (6) Did the provider recommend a suction toothbrush for the individual or refer to Dental clinic? (7) Did the provider refer the individual to the QDDP or the PNMT nurse after the last diagnosis of aspiration pneumonia? (11) Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made? (12) Did the provider review the medications to see if any changes or additions were needed to reduce the risk of aspiration pneumonia? o Diabetes mellitus (3) Did the provider order appropriate diagnostics and consults if warranted? (5) Did the provider order appropriate diabetic diet or consult with dietician for needed changes to diet? ▪ A Medical Provider Exit Interview was conducted on February 8, 2013. The following were noted in the exit interview: o Areas needing improvement were listed/identified as: the auditor noted that there was no discussion recorded in the PCP IPNs concerning risk factors, precipitating factors, medication review, or plan of care focusing on prevention of aspiration pneumonia. It was noted that the auditor did not review other documents, but focused on the content of the IPN. There was also no system to ensure referral for a dental evaluation prior to initiating bisphosphonate therapy. o Areas considered strengths were listed/identified as: the Quarterly Drug Regimen Reviews were up-to-date, and reviewed and signed in a timely manner. The annual physical exam was up-to-date, and considered informative. The 90-day medication orders included the required parameters of dosage, frequency, route, duration, and diagnosis for all medications. ▪ Compliance rates were calculated as an average of all PCP scores. ▪ Compliance per PCP ranged from 58 to 92 percent. A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The QA nurse/QI Department compiled compliance data with corrective action plans for Round #7, and included both external and internal audit results in the same database. These indicated: o The QA Department tracked corrective action plan resolution every 30 days until resolution. o During this 30-day time period, the QA Department tracked 55 corrective actions and determined that four of four (100%) providers	

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		corrected all deficiencies. o The corrective actions also generated a list of in-services or reviews to be completed with the goal to prevent recurrence of the need for future corrective action. In-services for addressing legibility, completion of consultation referrals with pertinent clinical current and past medical history, ensuring medication orders for acute condition included indication and duration for all medications prescribed, and documenting all consultation recommendation in the IPN within five business days of receipt were completed in 2012 or 2013. In-services that had not been completed included ensuring future annual medical assessments include all pertinent information, and ensuring documentation of all abnormal diagnostic tests and follow-up in the IPN. ▪ The Medical Department staff meeting minutes documented a discussion of the results of the external peer review results for prior audit results. There did not appear to be a review of trends in any formal meeting minutes, nor recent in-service reviews to address the additional in-servicing needs the QA Department listed. o The Medical Department submitted an in-service with attendance roster for the topic: Medical Provider Audit, internal and external audit process, dated 3/29/12. This reviewed several of the specific audit questions/indicators in the general audit tool. o Additional specific medical staff in-services included documenting the time of orders, and the diagnoses being treated with the order, including telephone orders. IPNs were to be dated and timed. This in-service occurred on 3/1/13. The process of on-campus and off-campus consultations was reviewed on 5/3/13. The topic: Consultant policy and Letters was in-serviced 5/3/13. An in-service was completed on 3/5/13 concerning medication orders having an indication and duration of treatment. Currently, six diagnoses had audit tools to monitor medical management compliance. It is recommended that additional diagnoses that are frequently found in the IDD population at LBSSLC be included into the audit process, such as dementia, GERD, and the finding of frequent falls. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days prior to the Monitoring Team's visit. Since the start of the Monitoring Team's last visit, three deaths had occurred: ▪ The average age was 62 (range from 55 to 71). ▪ Two died under the age of 65, and one died at age 65 or greater.	

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		▪ Of the deaths, two were females, and one was male. ▪ The causes of death were: complications of endometrial cancer with sepsis, aspiration pneumonia, and acute peritonitis with perforated small bowel. ▪ An autopsy was performed in one of the three (33%). ▪ DNR status was ordered while residing at LBSSLC [out of hospital (OOH) DNR] for zero of the three, and ordered for two while in the hospital. ▪ DNR status was in place prior to the final acute illness for zero of three individuals. DNR status was initiated during the final acute illness for two of three individuals. ▪ Two died in a hospital setting. ▪ One died at the Facility. ▪ Three of three had one or more hospitalizations within six months prior to death. ▪ Two of three had been hospitalized within four months of death. ▪ Two of three had an enteral feeding-tube. ▪ Three of three (100%) included documentation indicating they were aggressively treated or aggressively treated until a decision of DNR was made. ▪ Zero of three were enrolled in hospice. ▪ Two of three were considered ambulatory (either independently or with assistance). Since the Monitoring Team's last visit, three clinical death review investigations were completed. Three administrative death reviews were completed. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. The clinical death reviews generated no recommendations. It is recommended that a list of areas of medical care be created, and reviewed during each clinical death review to ensure all areas have been addressed. Clinical death review recommendations also are one way to include other aspects of health care that affect direct medical care (e.g., notification in a timely manner; documentation by nursing and direct support professionals; quality of documentation by nursing, habilitation services, and other departments; use of consultations; timeliness of consultations; transportation issues; use of generic versus brand names, etc.). Before no recommendations are listed as the final outcome of the review, it is suggested that each area of medical care be reviewed and documented as reviewed. The following reviews the findings of the administrative death reviews: ▪ Of these death reviews, three of three (100%) administrative death reviews had follow-up recommendations.	

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		▪ Administrative death reviews included from five to six recommendations per review, for a total of 16 recommendations. ▪ Systemic issues related to potential improvements in medical care were included in three of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were included in eight of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in transition of care to the ER, hospitalization, rehabilitation or nursing home, or hospice were included in zero of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in pharmacy services were included in zero of the 16 recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were included in zero of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies were included in zero of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in non-medical care were included in three of the 16 recommendations. ▪ Systemic issues related to potential improvements in meaningful day activities (i.e., work, leisure programs, etc.) were included in zero of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to documentation were included in two of the 16 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in other departments (i.e., maintenance, housekeeping, furlough, etc.) were included in zero of the 16 recommendations from the administrative death reviews. ▪ The Facility submitted follow-up documentation for 10 of 16 recommendations (63%). It is recommended a tracking system be created to ensure closure of administrative death review recommendations. The Monitoring Team was able to match closure evidence to some recommendations, but there appeared some recommendations for which there was no submitted information. Development of a two-column system identifying the recommendation and the closure evidence, with an appendix of closure information/evidence, would provide the Facility with a way of tracking closure, as well as provide the basis for future compliance in this area. Additionally, for any training component, a copy of the content of the training and training roster, with number trained and denominator of total number that need training according to the recommendation is important.	

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		The external medical peer review process appeared to be intact and appeared sustainable with a 20 percent review of Facility records over the year. A system was in place to monitor corrective action plans for areas needing improvement. The other component in this section, the follow-up of recommendations from administrative death reviews, needed further review by the Facility, as it did not appear all recommendations had evidence of closure.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	<u>Medical Department Internal QA System</u> The data from three internal medical peer reviews was provided. Since the Monitoring Team's last visit, the first internal medical peer review occurred November 14, 2012 through November 15, 2012. The General Medical Audit (Round #6) was completed on 12 records randomly chosen by the QA Department. The Medical Management Audit was completed on nine records randomly chosen by the QA Department. Topics included seizures, constipation, and UTI. For the General Medical Audit, PCP compliance in essential areas ranged from 94 to 100 percent. PCP compliance in non-essential areas ranged from 95 to 100 percent. For the Medical Management Audit, PCP compliance ranged from 40 to 100 percent. Compliance for the constipation audit was 77 percent. Compliance for the seizure audit was 91 percent. Compliance for the UTI audit was 75 percent. Based on the Facility's reviews, identified strengths included: the Active Problem List, consultation reports, lab/x-ray reports, and QDRRs were all signed and dated in a timely manner. Allergies were listed at the top of the physician order sheet. The SOAP format was utilized. There was timely intervention in response to abnormal diagnostic test results. Seizure control and referral were appropriate. For constipation, there was appropriate use of medications. Treatments and interventions for UTI were considered appropriate. Areas that appeared to need improvement from the General Medical Audit included answers to the following audit probe questions: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? (16) Do the medication orders for acute conditions include indication and duration for all medications prescribed? (22) Is the provider's documentation legible? and (29) Does the integrated progress record include a clinical assessment and a SOAP note from a provider within 24 hours of the readmission to the SSLC from a hospital/ER or LTAC [Long Term Acute Care]? Areas that appeared to need improvement from the Medical Management Audit included	Noncompliance

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		answers to the following audit probe questions: ▪ Constipation (3) Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects? (4) Is there evidence that the PCP ordered non-pharmacological treatments? (5) Did the provider complete a physical assessment and provide further intervention for the individual who was identified as having no BM after medical interventions? ▪ Seizures (2) Did the PCP complete appropriate labs at least every 6 months? ▪ UTI (3) Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN of that individual's response? (4) Did the provider order a urology consult or other diagnostics if a male individual has had more than one UTI in a year or a female individual has had more than three UTIs in a year? For this internal medical peer review, the general medical and medical management audits generated 14 corrective action plans. The QA Department submitted a document entitled "Medical Provider Audit report, Round 6 Internal Audits (Conducted November 2012)." This listed 15 corrective actions, but the summary of the document listed 16 correction actions. The reason for the non-agreement of data remained unclear. However, the QA Department tracked the corrective actions until resolved every 30 days. After 30 days, there remained 14 outstanding corrective actions. At day 60, there remained one outstanding corrective action, and at day 90, there remained one outstanding corrective action. The corrective actions also generated a number of in-services to be provided based on the findings. The need for an in-service for legibility was noted, and was last provided on 3/29/12. The need to address indication and duration on medication orders was last in-serviced on 3/5/13. The need to address providing a SOAP IPN with readmission to LBSSLC was also generated as a needed training, but had not been provided as of 7/12/13. The second peer review occurred from February 12, 2013 through February 13, 2013 (Round #7). The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 83 to 100 percent. Compliance for PCPs in non-essential areas ranged from 88 to 100 percent. Areas that appeared to need improvement included answers to the following audit probe questions: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? (18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? (21) Is each of this person's progress notes and orders signed, dated, and timed? (22) Is the provider's documentation legible? (25) Has the provider ordered appropriate consultations for identified need and diagnosis? (26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with	

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		the consultant? (27) Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? An internal medical management audit was completed from February 12, 2013 through February 13, 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: osteoporosis, aspiration pneumonia, and diabetes mellitus. ▪ Compliance among PCPs ranged from 78 to 100 percent. ▪ Areas that appeared to need improvement included answers to the following audit probe questions: o Osteoporosis (2) Did the PCP order a DEXA scan to be completed within the past 5 years? (3) Is there a diagnosis of a pathological fracture? o For Diabetes mellitus and Aspiration pneumonia, there were no areas identified as needing a corrective action. A report was generated on the results of this internal medical provider review, dated 2/15/13. The report summarized the key findings of the internal audit for February 2013. Eleven records were evaluated for the general medical audit and nine records were evaluated using the medical management audit. These were the same records used by the external auditor. All four PCPs participated in the audit process. No significant areas were identified needing immediate correction. Care was "found to be appropriate and timely." Strengths identified by this internal review included, that annual assessments were current, allergies were appropriately documented, preventive care and immunizations were up-to-date, QDRRs were addressed without issues, and acute care was considered appropriate. Challenges identified by the Medical Department included: ensuring the Active Problem List was updated, attention to IPN completion (i.e., with signature, time and date), documenting with legible hand writing, and ensuring consultation request forms included current and past medical history relevant to the concern. The third internal medical peer review occurred from May 14, 2013 through May 17, 2013. Thirteen records were chosen randomly by the QA Department. Nine records were chosen randomly for the medical management audit with three records each for the topics: seizures, constipation, and UTI. Based on the Facility's review, strengths included: improvement in the updating of the Active Problem List, essential items generally scored high, and good compliance with adhering to timeframes for signing the QDDRs, labs, x-rays, and consultant reports. For the internal general medical audit, PCP compliance for essential areas ranged from	

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		93 to 100 percent. PCP compliance for non-essential areas ranged from 89 to 100 percent. PCP compliance for the internal medical management audit ranged from 89 to 100 percent. Compliance for each diagnosis was determined. For constipation, compliance was 92 percent. Compliance for seizures was 100 percent. Compliance for UTI was 90 percent. For the General Medical Audit, areas needing improvement included: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? (9) Have the appropriate immunizations been given? (23) Is the provider's clinical assessment documentation organized in appropriate SOAP format (including assessment and plan)? (25) Has the provider ordered appropriate consultations for identified need and diagnosis? (26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant? (27) Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? For the Medical Management Audit, areas needing improvement included: ▪ UTI (1) Is urinary tract infection listed on the Active Problem List? ▪ Constipation (4) Is there evidence that the PCP ordered non-pharmacological treatments? The May 2013 internal medical peer review for the general medical audit and medical management audit generated 11 corrective action plans. The QA Department tracked follow-up closure of 11 corrective actions. Eleven of the corrective actions remained unresolved at 30 days following the audit. Eleven of the corrective actions remained unresolved at 60 days following the audit. One need for in-service was generated: future referrals for consultation would include pertinent current and past medical history. The QA Department had received information that this in-service was completed 5/3/13, but the need for corrective action occurred after the in-service was provided. <u>Inter-rater reliability</u> The inter-rater reliability for the past six months was provided by the QA Department for the General Medical Audit and Medical Management Audit (i.e., Aspiration pneumonia, diabetes mellitus, and osteoporosis) for February 2013. For the external and internal general medical audits, inter-rater agreement varied from 84 to 96 percent for record reviews of PCPs. For the medical management audits, inter-rater agreement varied from 56 to 90 percent. For the PCP responses to the medical management audits, overall agreement ranged from 57 to 92 percent, with an overall agreement of 62 percent. On 3/21/13, the Medical Department and QA Department met to discuss Section L	

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		quality improvement. This was expected to be the first of monthly meetings, and notes were recorded to formalize the discussion. It was documented at this meeting that the medical provider audit was developing into a mature process. The PCPs understood the expectations, the data reviewed, and the PCP role in resolving corrective actions in a timely manner. There were no other monthly meeting minutes submitted for this Medical Department and QA Department meeting. The issue of the need to establish inter-rater reliability was not addressed in the minutes that were provided. <u>Medical Department Internal Reviews/Initiatives and Improvement Projects</u> The Medical Department implemented the following additional processes for internal peer reviews: Quality indicators were identified for nine clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. Topics included: constipation, Diabetes mellitus, Down's syndrome, Metabolic Syndrome, Emergency Room/Hospital Visits, Osteoporosis, Aspiration pneumonia, seizures, and Prader Willi syndrome. These additional internal reviews occurred from September 2012 through June 2013, and the results indicated the following percentage compliance per topic for Quarter 4 of 2012 and Quarters 1-2 of 2013:	

Topic	September to November 2012	December 2012 to February 2013	March to May 2013
ER/hospital visits	80%	100%	100%
Osteoporosis	NA	100%	NA
Asp Pneumonia	NA	NA	100%
Prader Willi	NA	100%	NA
Seizures	NA	NA	100% (5/13-6/13)
Constipation	90%	100%	61%
Diabetes mellitus	88%	100%	NA
Down's Syndrome	NA	95%	NA
Metabolic Syndrome	100%	100%	100%

These quality indicators were an important step in expanding the measurement of care to various diagnoses common to individuals at LBSSLC. It was noted there were several errors in database management. For one internal review, the quality indicators showed no data had been collected, but compliance was 100 percent. In another review, data was listed as having been completed in August 2013. These were database entries reflecting the need for more formal training and restricting those able to edit and enter

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		data to those completing the training successfully. Although the compliance score of all questions for each of the nine topics is helpful in determining which areas/diagnoses need improvement, it is important to demonstrate the breakdown of those questions needing further review, and how the Medical Department responded in providing in-service training at a medical staff meeting, an on-site educational session, etc. It is recommended that specific questions with less than 90% compliance over several quarters be tracked for improvement, with development of corrective actions, if necessary. However, the greater concern was that the Medical Department did not notice these errors, which indicated the data had not been reviewed. The intent of a complete and accurate database is to guide the department in continual improvement processes. However, to date, it appeared the data collection had not been utilized. If it had been reviewed, then the discrepancies would have been found and corrected at an earlier time. The Medical Department needs to ensure it is creating databases, which will have value in guiding them in improvement and monitoring, and dedicate routine time to review data for this purpose. The Medical Department continued to track the reason for ER visits and hospitalizations. Data was available per month and per quarter from April 2012 through March 2013. This appeared to be accurate and important information, but it was not communicated how often this information was shared at a medical staff meeting or at the provider morning meeting. For substantial compliance, there will need to be evidence the databases are reliable, that the data is accurate and complete. Additionally, this section requires demonstration of a functioning departmental quality improvement system. That will require that the data developed is not for the purposes of the Monitoring Team only, but is used by the Medical Department in developing systems processes for improvement. New endeavors based on analysis of the data will need to be demonstrated.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of	Since the Monitoring Team's last visit, the following policies/procedures/protocols were approved and/or implemented: ▪ "LbSSLC – Health Services: Process for on-Campus and off-Campus Consultations," dated 5/3/13. For compliance to occur for this Section, a current Medical Department policy and procedure manual would need to be in place, with policies approved and implemented. There should also be a mechanism of yearly updating of the policies/procedures/	Noncompliance

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	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.	protocols on a continual basis. This manual should include the following topics: ▪ Staffing and administration - caseloads, categories of topics for CME, CPR certification, etc.; ▪ Organizational procedure and role of the morning provider meeting; ▪ Routine care and documentation standards; ▪ Updating diagnoses using IDC and DSM nomenclature; ▪ Preventive care; ▪ Acute care; ▪ Utilization of clinical guidelines and national standards as part of practice pattern; ▪ Tracking and addressing missed appointments; ▪ External peer review; ▪ Internal peer review and inter-rater reliability; ▪ Role of QA/QI Department in monitoring/guiding the Medical Department; ▪ Internal QI monitoring initiatives; • Mortality reviews and recommendations; • Role of ethics committees; and • Others as indicated. No current manual was provided for review to ensure the above areas were included, as well as to ensure the policies were reviewed in the prior 365 days. In its comments on the draft report, the State indicated policies existed for a number of the topics listed, and work was ongoing to develop a procedure for the morning meeting. At the time of the next review, the full manual should be provided for review.	

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 At-Risk Individuals list; o LBSSLC's Nursing Department Presentation Book; o LBSSLC's nursing staffing data; o LBSSLC's Nursing Monitoring Tools and data; o LBSSLC's Action Plans for Nursing; o LBSSLC's lists of individuals who were seen in the emergency room, and hospital; o Medical records for the following individuals: Individual #258, Individual #136, Individual #6, Individual #209, Individual #181, Individual #317, Individual #35, Individual #74, Individual #147, Individual #225, Individual #149, Individual #2, Individual #181, Individual #217, Individual #61, Individual #52, Individual #82, Individual #74, Individual #156, Individual #202, Individual #51, Individual #89, Individual #3, Individual #1, Individual #281, Individual #9, Individual #97, Individual #73, Individual #75, Individual #130, Individual #171, Individual #128, Individual #232, Individual #113, and Individual #242; 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 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 for 11/15/12, 1/11/13, 2/14/13, and 4/4/13; o LBSSLC's list of individuals affected by outbreaks; o Quarterly Emergency Response Drill data; o Standard Precautions Monitoring Tool data; o Procedure to Count Medication Each Shift; o Residential Medication Pass Observation data; o Infection Control data reports by month, home, and person; o Medication Observation raw data; o Completed Medication Variance forms; o Unexplained Returned Units of Medication data; o Returned Medication data by home; o Medication Observation Tracking data; o Medication Variance data and graphs;

	○ Pharmacy Spot Check Medication Accountability Audit data; ○ Unexplained Returned Medication Doses data; ○ Medication Safety and Systems Committee meeting minutes, dated 11/14/12, 12/20/12, 1/23/13, 2/27/13, 3/20/13, 4/24/13, 5/30/13, and 7/9/13; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 10/2/12, 12/6/12, 2/6/13, 4/3/13 and 7/10/13; and ○ LBSSLC staff follow-up monitoring form for Medication Administration Record blanks and data. ▪ **Interviews with**: ○ Brandi Villarreal, RN, BSN, Chief Nurse Executive; ○ Lilly Burton, RN, Program Compliance Nurse (PCN); ○ Lisa Murphey, RN, BSN, Nurse Educator; ○ Scott Craig, RN, BSN, Case Manager Supervisor; ○ Eddie McFadden, RN, Quality Enhancement (QE) Nurse; ○ JJ Sorele, RN, BSN, Infection Control Nurse (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; ○ Susanna Cantu, RN, Hospital Liaison; ○ Joe Gariety, Interim Risk Manager; ○ Linda Thomas, OTR, Director Habilitation Therapy; ○ Ric Savage, State Office Consultant; ○ Norma Guterrez, Safety Officer; and ○ Matt Peterson, Training Specialist I. ▪ **Observations of**: ○ Medication Administration in the Sparrow; ○ Use of emergency equipment at Canna and Quail; and ○ Medication Safety and Systems Committee meeting, on 7/9/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. 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. Since the last review, the Health Monitoring Tools for Nursing had been revised and consolidated into six tools. The Monitoring Team's review of the revised Monitoring Tools found problematic issues that could compromise the reliability of the data generated and result in insufficient measurement of the quality of the nursing services and documentation. (Specific details are provided with regard to Section M.1) At the time of the review, the Facility had only recently implemented the revised nursing monitoring tools and

	reported that there had not been enough data generated to conduct analyses. In addition, the Facility reported that due to significant staffing challenges in the Nursing Department, since the last review, most of the previous monitoring activities had been suspended. Although very little data was included in the Self-Assessment for Section M, the data presented indicated that there continued to be significant problematic issues regarding the format, the organization, the presentation, the interpretation, and analysis of the Facility's data. o Although very limited, it was unclear why the specific data included in the Self-Assessment were presented since much of it was not related to the specific provision, did not identify the specific standards used to determine compliance for the different areas audited, and did not reflect the quality of the nursing services and documentation. o In most of the subsections for Section M, many of the items presented did not reflect review of the quality of the services provided and documentation for each area upon which the Monitoring Team's findings focused and the Settlement Agreement required. 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. o In addition, there was no inter-rater reliability reported for any of the monitoring tools. From the problematic issues the Monitoring Team found regarding the recently revised Health Monitoring Tools (discussed with regard to Section M.1) that could affect the consistency in monitoring and the validity of the results, it was likely that different auditors would score compliance differently. ▪ The Facility did not have a plan for consistently presenting the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently present findings based on specific, measurable indicators, and in alignment with the specific provision. For example, as noted above, at times, without citing a standard, such as a nursing protocol, it was unclear what criteria had been used to determine compliance. In addition, the lack of specific details explaining items in the Self-Assessment rendered much of the information meaningless and uninterpretable. In some cases, the information did not make any sense. o Did not address the quality as well as the completion of documentation. o Did not consistently identify the sample sizes used for some of the monitoring, including the description of the overall population from which the sample was selected (N) and a percent sample size. 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 subsections of Section M. This was consistent with the Monitoring Team's findings. However, of concern, most of issues noted in the Self-Rating sections indicating the rationale for the lack of compliance were not mentioned in the activities conducted to determine the Facility's compliance with the various provisions. The Facility's data identified some of the areas that were in need of improvement, but did not provide any

	information regarding initial attempts at analyzing the information, identifying some potential causes for the issues, and possible barriers to improvement. In addition, significant work was needed regarding the analysis of the data and connecting any monitoring 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 staff nursing positions as well as a complete turnover in the key leadership nursing positions. Due to these staffing issues, the Facility had to utilize Agency nurses to cover many of the vacant positions, and continued to do so at the time of the review. Some of the changes regarding the Nursing Department and nursing positions since the last review included the following: ▪ In May 2013, the Chief Nurse Executive (CNE) position was filled; ▪ In May 2013, a Program Compliance Nurse position was added and filled; ▪ In January 2013, a Nurse Educator was hired; ▪ In June 2013, the Case Manager Supervisor position was filled; ▪ In June 2013, an Infection Control Nurse was hired; and ▪ In June 2013, the Nurse Operations Officer (NOO) position became vacant and remained vacant at the time of the review. At the time of the review, most of the leadership positions only recently had been filled within the past two months resulting in the Nursing Leadership Team still being somewhat unfamiliar with their roles and responsibilities. Since none of the new nursing leadership staff had virtually any overlap with their predecessors, the Monitoring Team found that a number of promising systems that had been previously implemented, unfortunately, had not been maintained. However, some of the Facility's positive steps forward included: ▪ A Program Compliance Nurse position was added to the Nursing Department and filled in May 2013 to assume the monitoring responsibilities for nursing. ▪ The data from December 2012 through May 2013 indicated that 120 (99%) of 121 total Emergency drills that were conducted were deemed as passing. ▪ A review of the Facility's data indicated that the required daily emergency equipment checks completed by Risk Management staff were consistently being conducted. ▪ The Facility indicated that 100% of current RN Case Managers received training regarding the Individual Support Plan – At Risk Individuals procedure that included training regarding the Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP). The Facility also indicated that additional training regarding these areas had been provided to the staff by State Office Discipline Coordinators and/or Consultants, and should be completed for all staff by September 2013. ▪ The Facility implemented a Facility-wide system to decrease medication variances related to medications being given to the wrong individual that included the training of the direct support professionals regarding their responsibilities during medication administration in assisting the individuals and the nurse.

	▪ Since the last review, the pharmacy had initiated spot checks audits of the Medication Administration Records and the medication counts across all 15 residences. ▪ The Facility recently had implemented an enhanced procedure using charting codes in an effort to promote clearer documentation to make it easier to determine the reason for a returned medication. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, the significant regression, found regarding the infection control program, 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 troubling to the Monitoring Team at this stage in the review process. Unfortunately, the challenges in stabilizing the nursing coverage related to staff turnover, and the significant changes made in the nursing leadership positions since the last review had prohibited the Facility from making progress in most of the crucial areas affecting individuals' healthcare. However, it is the hope of the Monitoring Team that the time the Facility took to stabilize its nursing staffing and assess its nursing systems will result in an appropriately prioritized plan with sustainable positive systems and outcomes.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information addressing nursing documentation regarding restraints is included above with regard to Section C. 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: ▪ The documentation contained in the Facility's Self-Assessment indicated that since the last review, monitoring by Nursing Administration for documentation related to acute illness/injury/change of status was deferred until June 2013 due to staffing issues in the Nursing Department. In addition, the Facility indicated that a review of nursing documentation validated that there had been no improvement related to acute illness/injury/change of status and follow up to resolution. However, no information or data were provided indicating how this finding was determined.	Noncompliance

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		▪ The Facility indicated that when two vacant positions for Case Managers were filled as of June 15, 2013, the caseloads for each Case Manager should decrease from 17 to 14 individuals. ▪ Although the Facility Assessment indicated that a review of data addressing the emergency response drills found that 55 of 55 (100%) of the drills passed, there was no specific information provided such as the timeframe for when these drills were completed in order to accurately interpret the data. ▪ In addition, the Facility indicated that the monthly emergency cart checks data from November 2012 to April 2013 was reviewed, and that "any errors noted were immediately addressed and corrected." However, no specific information was included regarding the findings of the review. ▪ Consequently, due to the significant lack of information contained in the Facility's Self-Assessment for M.1, the Monitoring Team was not able to ascertain what specific activities the Facility was conducting to review its progress regarding this requirement of the Settlement Agreement. <u>Self Rating</u> The Facility's Self-Assessment indicated that "based on this self-assessment, this provision is not in substantial due to lack of improvement in documentation, lack of monitoring, trending, and/or analysis being completed to determine compliance." Discussions with the Chief Nurse Executive indicated that since the last review, the Facility had had major staffing challenges, including a complete turnover in the key nursing leadership positions, and that efforts regarding recruitment and retention continued to present challenges. Interviews with the CNE, Quality Assurance Nurse, and the Program Compliance Nurse indicated that since the last review, very few monitoring activities had been conducted resulting in little to no data generated addressing the requirements of the provisions for Section M. The exception to the suspension of monitoring was the Medication Administration Observations. Although very little data was contained in the Self-Assessment for Section M, from the few data presented, it was evident that there continued to be significant problematic issues regarding the format, the organization, the presentation, and the interpretation and analysis of the Facility's data. It was clear to the Monitoring Team that the Nursing Department continued to lack basic understanding regarding collecting monitoring data, organizing it in a meaningful way, and taking steps to interpret the findings. As the Facility begins to generate more monitoring data for Section M, it is the Monitoring Team's hope that the ongoing analysis of data should then result in the development and implementation of plans of action addressing the areas that reflect problematic trends. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and then provide training to the disciplines regarding	

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		how to analyze their data to identify problematic trends. Since the last review, the State had modified the Nursing Health Monitoring Tools (HMTs) including reducing the number of tools to six. These included: ▪ Annual Nursing Assessment Monitoring Tool; ▪ Care Plan Monitoring Tool; ▪ Nursing Infection Control Monitoring Tool; ▪ Nursing Pain Management Monitoring Tool; ▪ Skin Integrity Monitoring Tool; and ▪ Urgent Care/ER/Hospitalizations Monitoring Tool. The Monitoring Team's review of the HMTs found some significant problematic issues that would affect the reliability of the data generated, such as: ▪ The instructions contained on the tools addressing the nursing documentation did not indicate how the quality of the documentation was to be determined, such as using the nursing protocols as the standard for compliance rather than depending on auditor judgment; ▪ A number of items on the tools contained several elements within a given item making it difficult to identify which elements were in compliance and which were not. For example, one item contained on the Urgent Care/ER/ Hospitalizations Monitoring Tool included elements regarding a full set of vital signs, the chief complaint/presenting problem, a systems review including a skin assessment as appropriate, legibility, and accuracy. This one indicator was to be audited and scored either yes or no. However, in the event the item was found not to be in compliance, it would be difficult if not impossible to determine which of the above elements were found to be in or out of compliance, making it difficult to track trends and focus corrective actions plans on the problematic elements; and ▪ There was no mention in the items or the instructions on the Nursing Care Plan Monitoring Tool that the interventions found in the care plans should be in alignment with the assessments contained in the nursing protocols for specific health issues. Overall, the issues found in relation to the current Health Monitoring Tools were concerning in that they did not lend to generating an adequate and accurate review of the quality of the clinical care and treatment an individual(s) received. <u>Staffing</u> At the time of the review, LBSSLC had a census of 211 individuals. Since the last review, LBSSLC had significant changes regarding key leadership positions in the Nursing Department as well as staff nursing positions, which included:	

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		▪ In May 2013, the Chief Nurse Executive position was filled; ▪ In May 2013, a Program Compliance Nurse position was added and filled; ▪ In January 2013, a Nurse Educator was hired; ▪ In June 2013, the Case Manager Supervisor position was filled; ▪ In June 2013, an Infection Control Nurse was hired; and ▪ In June 2013, the Nurse Operations Officer position became vacant and remained vacant at the time of the review. In addition, at the time of the review, the Nursing Department had a total of 96 allotted positions. The nursing vacancies included five RN positions and five LVN positions. From a review of the Facility's nursing staffing data and discussions with the CNE, since the last review, the Nursing Department had experienced significant staffing challenges that warranted the use of Agency nurses. Data addressing staffing that was provided in the Facility's Self-Assessment indicated that the fill rate for the various nursing positions were as follows: LVN III – 84.44% LVN II – 0% RNIV – 80% RN III – 88% RN II – 90.48% At the time of the review, the Facility continued to experience staffing challenges and was regularly using Agency nurses to cover shifts on a daily basis. In addition, most of the leadership positions had only recently been filled within the past two months resulting in the Nursing Leadership Team still being somewhat unfamiliar with their roles and responsibilities. Since none of the new nursing leadership staff had virtually any overlap with their predecessors, the Monitoring Team found that a number of promising systems that had been previously implemented had not been maintained. 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 are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions such as the new addition of the Program Compliance Nurse position. <u>Quality Enhancement Efforts</u> Since the last review, the Facility continued to have two full-time Quality Assurance Nurses. At the time of the review, the new Program Compliance Nurse had not yet implemented the newly revised HMTs, and reported that she had spent most of her time since being hired putting together the Presentation Book for Section M. In addition, the QA Nurse reported that she had continued to conduct audits for some of the areas in nursing with only minimal data being generated. Consequently, the QA Nurse and PCN	

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		thus far had not yet established inter-rater reliability for any of the nursing monitoring tools. However, as noted above, the problematic issues found regarding the revised HMTs was of major concern in that the data generated might not accurately reflect the Facility's nursing practices. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ The CNE reported that all State-issued nursing protocols had been implemented and training provided. However, at the time of the review, little to no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments, identify the type of assessments that should be conducted, assist in determining the frequency of these assessments, and/or identify the parameters and time frames for reporting symptoms to the practitioner/physician and Physical Nutritional Management Team, if indicated. A review of 10 individuals' IPNs (i.e., Individual #258, Individual #136, Individual #6, Individual #209, Individual #181, Individual #317, Individual #35, Individual #74, Individual #147, and Individual #225) who had been transferred to a community hospital found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%) of the cases in alignment with the nursing protocols. ▪ The documentation indicated that the licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. Due to the lack of ongoing clinically appropriate nursing assessments, changes in status were only identified when the individual was already acutely ill. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments as dictated by the symptoms in none (0%) of the cases in alignment with nursing protocols. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in none (0%) of the cases in alignment with the individuals' overall medical status. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases in	

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		alignment with the nursing protocols addressing the specific health issue. ▪ The documentation indicated that all 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 identified during the past six reviews. The overall problematic issues that were found in all 10 records included: ▪ Although since the last review, an increase in nursing documentation was found in the IPNs, the documentation did not address the emerging clinical issues. This was due to the lack of a structured system driving the type of nursing assessments that should have been conducted for the health issues and the associated documentation of those assessments. This structure was available through the nursing protocols, but nurses were not using the protocols to drive their assessments and/or documentation. ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments; ▪ Due to the lack of consistent nursing assessments found in the documentation, it was largely impossible to accurately determine when changes in status were initially occurring; ▪ There continued to be a lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There continued to be inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of pro re nata (PRN) medications (as needed medications); ▪ There continued to be a lack of assessment and/or inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The IPNs continued to lack specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There continued to be 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 continued to be a 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 issues or receiving PRN laxatives; ▪ Physicians/Practitioners were not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was little documentation that nursing communicated with the PNMT	

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		regarding changes in status for individuals at risk of aspiration/choking; ▪ There was a lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ There was a lack of communication noted between shifts regarding status changes, and the need for regular nursing 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 IPNs, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was a lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ When nursing protocols were used to guide nursing assessments, they were found to be initiated only after the individual was ill and not as proactive measures to prevent the occurrence of acute health issues; ▪ Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations or in alignment with nursing protocols; ▪ Dates and times were not consistently documented for progress notes; ▪ Late entries were not appropriately documented according to nursing standards of practice; ▪ 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 some IPNs were found that contained an adequate nursing assessment, the lack of consistency of the nursing assessments rendered the overall care of the individuals insufficient to address their specific needs. Although the Facility reported that the nursing protocols had been implemented, there was no indication they were being used consistently to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices. In addition, mentoring and supervision of nurses should focus on the consistent use of the nursing protocols. As noted in several previous 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 specific action plans addressing the continuing problematic issues 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.	

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		Availability of Pertinent Medical Records From a review of records while on site, it was noted that some of documents were missing from the active records. For example, a number of the acute care plans addressing infectious issues were not found in the Active Records. From discussions with nursing, they were not permitted to put care plans into the records and had to have the records staff place them into the records. This could take up to three days, which was a barrier to clinical care. However, when this issue was addressed with the Quality Assurance Director, the process was promptly and appropriately modified and training provided during the review week. In addition, several Integrated Health Care Plans and Comprehensive Nursing Assessments were also found missing from the records. However, it was unclear if these documents were missing, had not yet been filed, or if the documents had not been completed. 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. Infection Control (IC) Since the last review, the previous Infection Control Nurse left the position in February 2013, and the Hospital Liaison Nurse was assigned as the interim IC Nurse in March 2013. From discussions with the Hospital Liaison Nurse, she indicated that she had no previous experience in infection control, and when she was assigned to cover the position, she received no orientation and had not received any training from the previous IC Nurse as to the systems and operations of the Facility's IC program. In June 2013, the IC Nurse position had been filled with a Registered Nurse with no previous experience in infection control. Consequently, the Monitoring Team found that a number of positive systems that had been implemented had not been maintained resulting in significant deficits in the area regarding infection control as noted below. ▪ The Facility had not continued to utilize the process addressing data reliability to accurately identify the Facility's trends related to infectious and communicable issues. The Facility had not been using the Drug Utilization Discrepancy Reports to identify any discrepancies regarding the infection control data to ensure that the data were reliable. Discussions with the CNE, Hospital Liaison Nurse, and the Infection Control Nurse indicated that the available IC data regarding acute infections and outbreaks were not reliable. Without data reliability, any identification of trends and analysis of IC practices is meaningless. ▪ Although the Facility had reported during the past review that the Immunization database was completed, the IC Nurse as well as the documentation contained in the Facility's Self-Assessment indicated that data was being entered into the	

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		immunization database with completion targeted for 6/30/13. Thus, there was no indication of progress regarding the tracking, trending and analysis of these data that was noted to be in the developmental stages during the last review. ▪ There was no documentation regarding Outbreak Timeline Investigations conducted since the last review, although there had been an outbreak of C-diff. In response to the Monitoring Team's request for the names of individual affected by any infectious outbreaks in the past six months, the Facility provided a list of eight individuals. However, from interviews with the CNE, Hospital Liaison Nurse, the Infection Control Nurse, and review of the Infection Control Committee meeting minutes, in January 2013, there had been at least 16 cases of C-diff reported, and in March 2013, 13 cases of C-diff were reported. Thus, the Monitoring Team was unable to reliably review the care and care plans for the individuals who experienced an infection related to outbreaks. In addition, there was essentially no clinical analysis or information contained in the Infection Control Committee meeting minutes regarding this outbreak. ▪ Since the last review, the content of the Infection Control Committee meeting minutes had significantly regressed in that they contained no information that data regarding infection control issues were being aggregated and analyzed along with other monitoring data addressing IC issues, as well as 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. ▪ Although the Facility indicated that they were entering data into 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. ▪ Although the Facility had been conducting some Real Time IC audits, the results of these 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 Committee meeting minutes.	

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		▪ Of major concern, and consistent with the same significant problematic issues that were found during the previous six reviews, was the lack of nursing care plans or adequate nursing care plans related to infectious diseases (the discussion related to Section M.3 includes specific details of these findings). Since the last review from the Monitoring Team, the significant regression noted in the area regarding Infection Control was of serious concern. Much of the solid steps forward regarding Infection Control that had been found during the past review had not been maintained. At the time of this review, LBSSLC had no system in place to ensure that individuals with infectious diseases were being tracked, monitored, and provided care plans that included the appropriate infection control measures and clinically appropriate interventions to prevent the spread of infections. <u>Mock Code Drills and Emergency Response Systems</u> Since the last review, LBSSLC indicated the following steps were initiated regarding this area: ▪ The Facility continued to conduct the required number of Emergency drills since the last review. ▪ The CTD staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data from December 2012 through May 2013 indicated that 120 (99%) of 121 total drills that were conducted were deemed as passing, which was a very positive finding. However, consistent with the findings from the last review, the Facility had not been conducting alternative scenarios. ▪ The Monitoring Team's review of the Facility's data verified that the required daily emergency equipment checks completed by Risk Management staff were consistently being conducted. ▪ At the time of the review, the Facility had established inter-rater reliability for the Emergency Drill tool at 100%. ▪ Since the last review, the QA Nurse continued to conduct emergency equipment drills for nursing after most of the Emergency Drills. Although the Facility implemented some positive steps 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: ▪ Although the CTD staff reported overall improvement, there continued to be some staff resistant regarding participation in the Emergency Drills. Specifically, the documentation reflected that for some drills conducted in May 2013, nursing staff did not respond and attend to the drill. ▪ During the review, the Nurse Educator reported that the Emergency Equipment Competency Checklist that should be conducted at least every quarter for each	

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		nurse had not been regularly conducted. ▪ In response to a request by the Monitoring Team for "any committee review of mock and actual medical emergencies," only raw data entitled "Emergency Drill Checklist-Department/QA Comparison" was provided. Thus, as noted from past reviews, there was no clinical review of the Mock Code Drills and the actual medical emergencies that occurred at the Facility. Consequently, the status of the Facility's emergency systems was not being reviewed, discussed, or tracked by any clinical staff. ▪ Although the Facility had acquired eight new Automated External Defibrillators (AEDs) during the previous review, it was troubling to the Monitoring Team that the CNE and Nurse Educator were not aware as to the total number of AEDs at the Facility and where each of them was located. In addition, as noted in the previous report, 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 Monitoring Team's observations of nurses demonstrating the emergency equipment at building 521 (Canna) and 504E (Quail) found that the staff that were observed were unfamiliar with the emergency equipment, and in fact, one nurse could not initially find the emergency cart in building 521. In addition, one nurse had difficulty finding the outlet to plug in the suction machine, indicating that it was rarely being checked for ensure it was operational. Also, another nurse verbalized that she was not familiar with the contents contained in the locked emergency box and stated: "so that is what that thing is" when the Nurse Educator pointed out a razor in the box. In addition, one of the nurses observed did not know how to turn off the AED. All the nurses observed needed several prompts to complete the demonstrations. The Monitoring Team also noted that the Nurse Educator conducting the demonstrations of the emergency equipment was unfamiliar with the process, and was prompted several times by the Monitoring Team to ask staff to demonstrate some of the equipment. In addition, she was noted to score items in compliance when the staff being observed clearly needed a number of prompts to accurately demonstrate or answer questions about the equipment rendering her data inaccurate. When asked about her unfamiliarity with the emergency equipment observation process, she reported that since she was hired in January 2012, she had not received any training regarding conducting the observations. Although the Facility had made some positive steps forward regarding LBSSLC's Emergency Response System, there continued to be significant problematic issues regarding the use and knowledge of the Facility's emergency equipment. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.	

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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. 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: ▪ The Facility indicated that a review of the timeliness of Nursing Comprehensive Assessments found that there was conflicting findings with the data generated by the Case Manager Supervisor resulting from discrepancies in the auditing process. Specifically, the assessments were not placed in the correct folder within the shared drive. In addition, conflicting data was found regarding the Annual Nursing Comprehensive Assessment between the Case Manager Supervisor's data and data from the QDDP Coordinator. The Facility also indicated no formal process was in place to address the quality of the Annual Nursing Assessments. Although the Facility reported that formal procedures would be developed addressing these issue, the lack of clear and specific instructions as well as the lack of inter-rater reliability established resulted in the Facility not having accurate and reliable datat to compare to future auditing activities. ▪ In addition, the Facility indicated that a review of the nursing documentation for two transitions found that they were "specific and detailed enough to maintain continuity of care in the community." However, the Facility's findings were not in alignment with the findings of the Monitoring Team's noted below. There was no indication contained in the Facility's Self-Assessment as to what criteria/standards were used to determine their findings. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "Based on this self-assessment, this provision is not in substantial compliance as assessment quality, timeliness, and additional monitoring is warranted to obtain compliance. Action Plans are in place to address these needs." 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 based on specific findings related to the significant problems with the quality of the content of the Comprehensive Nursing Assessments. At the time of the review, the CNE reported that due to the number of challenging staffing issues that affected the department since the last review, there had been a lack of overall progress made by the Nursing Department in addressing most of the provisions of the Settlement Agreement. <u>However, of major concern for the Monitoring Team was that thus far in the review</u>	Noncompliance

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		process, LBSSLC had not yet developed a clinically appropriate competency-based curriculum addressing the quality of the documentation that should be contained in the Comprehensive Nursing Assessments. In addition, due to the lack of implementation of the nursing protocols resulting in the lack of relevant nursing assessments being conducted on the individuals, there was a significant absence of clinical data generated during the past several quarters to even analyze. Consequently, the Monitoring Team continued to find the Facility's Comprehensive Nursing Assessment to be clinically inadequate. As found during the past six reviews, the findings of the Monitoring Team noted below reflected that the nursing staff at LBSSLC continued to lack competency with this requirement of the Settlement Agreement. The Quarterly/Annual Nursing Assessments for 23 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; and Individual #113 and Individual #242 for fluid imbalance. ▪ Of the 23 individuals' nursing quarterly assessments reviewed, 18 (78%) were timely completed. Assessments not timely completed included those for: Individual #82, Individual #74, Individual #51, Individual #89, and Individual #171. ▪ 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. The Monitoring Team found that there had been no progress made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. Consistent with the findings from the previous six reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. Although LBSSLC's action plan addressing this requirement did include action steps	

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		regarding improving the quality of the nursing assessments, it was questionable from interviews conducted on site during the review week if the current management staff was able to determine what constituted a quality nursing comprehensive assessment and summary. This was very troubling to the Monitoring Team at this juncture of the process. The consistent lack of progress found regarding the quality of the Comprehensive Nursing Assessments continued to be very concerning to the Monitoring Team due to the potential impact it had on the health and wellbeing of individuals residing at the Facility. As noted previously, this area should be considered a priority. It is essential that nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health status. Appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the nursing documentation and Nursing Discharge Assessment Summary for one individual, Individual #2, found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individual. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment for the individual was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%). ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues for the individual in none of the one (0%) records reviewed. Consistent with the findings from the previous reviews, a number of problematic issues were found in the nursing documentation reviewed for Individual #2, including: ▪ A lack of a comprehensive and specific nursing assessment for an individual who had experienced a stroke five months prior to the individual being discharged/transitioned to the community; ▪ A significant lack of clinical assessments for clinical health indicators, especially addressing being 20 pounds underweight (current weight was noted to be 61 pounds and desired weight range was listed as 80-108 pounds) at the time of the discharge/transition to the community;	

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		▪ A lack of an analysis of the individuals' health/mental health issues especially regarding change in functioning related to the stroke; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments. This was evidenced by discrepancies in the information that were not identified or corrected prior to the individual's transition. For example, the Nursing Discharge Summary, dated 11/13/12, indicated that: "recommendations are to be seen under general anesthesia" for dental care. However, the document entitled In-Service for Individual #2 stated the anesthesiologist had reviewed the individual's record and reported that: "he is not a candidate for general anesthesia due to the change in medical history of the stroke and his recent weight loss." ▪ A lack of clear information addressing the nursing interventions that were needed to care for the individual. Again, as noted in previous reports, 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. Although the Facility's Self-Assessment indicated that the nursing documentation for transitions were found to be "specific and detailed enough to maintain continuity of care in the community," the findings from the Monitoring Team found quite the opposite. The significant discrepancy in findings was very concerning. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision.	
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. LBSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that 100% of current RN Case Managers received training regarding the Individual Support Plan – At Risk Individuals procedure, including the Case Manager Supervisor. ▪ The Facility's Self-Assessment indicated that at the time of the review, "there were no systems in place related to nursing care plans." However, the Facility reported that in May 2013, the CNE completed a random review of six Acute Care Plans and found individualization, interventions, goals, and direct support professional instruction were adequate for all six (100%) reviewed. As noted below, the Facility's findings were not in alignment with the findings of the Monitoring Team. ▪ In addition, the Facility's Self-Assessment indicated that a review of a 30% (14) random sample of the ISPs scheduled from January through April 2013 found that one of 14 (7%) had evidence that the Integrated Health Care Plan (IHCP)	Noncompliance

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		was implemented within 14 days and only six of 14 (43%) IHCPs were available within the records. The Facility reported that a system for tracking the completion and implementation of IHCPs would be implemented. However, no data were provided to assess whether care plans were in alignment with the nursing protocols for the specific health issues, which is crucial to the quality of care planned for the individuals. Self-rating: The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance as IHCPs are not implemented timely with lack of monitoring and trending with corrective actions taken." The records of 23 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance. Of the 23 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Nineteen (83%) were found to have a care plan addressing their high or medium risk health/mental indicator. Individuals who did not have a related care plan included Individual #217, Individual #52, Individual #51, and Individual #130. ▪ None (0%) of the nursing interventions contained in the 19 care plans 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, none of the nursing interventions listed in the care plans reviewed were in alignment with the nursing protocols addressing the specific health issues. ▪ None (0%) of the 19 care plans were found to be clinically adequate. There was no indication that any types of nursing assessments were to be conducted addressing the specific health issue in alignment with the nursing protocols. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ None (0%) of the 19 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 19 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 19 care plans, validating the implementation of the interventions was not possible, rendering	

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		them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. At the time of the review, the Facility continued to have a variety of formats of care plans that included Risk Action Plans, Acute Care Plans, and Health Management Plans, although teams were in the process of transitioning to using the Integrated Health Care Plan format. However, it was concerning to the Monitoring Team to note the lack of progress since the last review in the content of the care plans regardless of the format used. The current findings of the Monitoring Team regarding this provision indicated that the promising process of transitioning to the IHCP had thus far resulted in the repetition of previous problematic issues that existed regarding care plans. Specifically, some of the problematic issues identified in the previous Health Management Plans that were found in the current IHCPs included: ▪ 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 risks. ▪ IHCPs/Risk Action Plans/Care Plans were not consistently found in the Active Record. ▪ The goals listed in the care plans found did not address the etiology of the health problem as an objective clinical indicator to focus on. Consequently, most action steps found in the care plans did not address the underlying cause of the health issue and had no association with the goals listed. ▪ None of the nursing action steps found in the care plans were in alignment with the clinical assessments required by the nursing protocols for the specific health issues. ▪ The action steps contained in the care plans frequently 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; noting consistently 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 basically generic, and non-specific to the individual's health care needs. ▪ At the time of the review, the care plans reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. ▪ The generic nature of the action steps prohibited validation that the step was actually being implemented.	

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		Regardless of the system and system changes made to the Facility's overall plans of care, it is imperative that the Facility addresses 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. As noted with regard to Section M.1, since the last review, there had been turnover in the Infection Control Nurse position that included a period of time that the position had been vacant. Although the Hospital Liaison Nurse reported she had been assigned to cover this position until the position was filled, she stated she had received no orientation to the position or the responsibilities and duties. Consequently, much of the tracking systems regarding infection control issues had not been maintained since the last review, including ensuring reliability of the IC data. In response to the Monitoring Team's request for the names of individual affected by any infectious outbreaks in the past six months the Facility provided a list of eight individuals. However, from interviews with the CNE, Hospital Liaison Nurse, the Infection Control Nurse, and review of the Infection Control Committee meeting minutes, in January 2013, there had been at least 16 cases of C-diff reported, and in March 2013, 13 cases of C-diff were reported. Thus, the Monitoring Team was unable to reliably review care plans for the individuals who experienced an infection related to outbreaks and was not able to accurately score the following metrics: ▪ Of the episodes, ____ (___ %) were found to have had an acute care plan addressing the infectious issue. ▪ Of the ___ Nursing Care Plan reviewed, ___ were found to be clinically adequate (___ %). At the time of this review, LBSSLC had no system in place to ensure that individuals with infectious diseases were being tracked, monitored, and provided care plans that included the appropriate infection control measures, and clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurses 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. For progress to be made regarding this provision of the Settlement Agreement, the 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	

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		interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. Overall, there had been essentially 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. With regard to this provision, LBSSLC's Self-Assessment indicated the following: ▪ The documentation contained in the Facility's Self-Assessment indicated that since the last review, the Nurse Educator position was filled in November 2012 and assumed the duties in early December 2012. ▪ In addition, the Facility's Self-Assessment indicated that at the time of the review, 30 out of 44 RNs had completed the State-wide Physical Assessment class. The new Nurse Educator received this training at Denton SSLC in May 2013, and will be conducting the training for the remaining RNs needing this training. ▪ The Facility indicated that a review of Nursing Protocol cards showed all cards had been implemented and in-serviced to existing nurses, new employees, and agency nurses. However, the monitoring of Nursing Protocols was suspended due to staffing challenges related to turnover and significant changes within nursing leadership positions, and would be resumed in June 2013. This would include establishing inter-rater reliability between the Program Compliance Nurse and the Quality Assurance Nurse auditors. However, from discussions with the CNE, Program Compliance Nurse, and QA Nurse, the procedure for nursing protocol auditing and analysis involved the auditors reviewing one of the Integrated Progress Notes related to a health issues to determine if it demonstrated that the nursing protocols were used. Reviewing one IPN does not usually capture the entire clinical picture of care provided to an individual from the identification of a change in status to the resolution or need for ongoing assessments in alignment with nursing protocols. Consequently, the Facility's conclusions regarding compliance with implementation of the Nursing Protocols could likely be erroneous. Although the Monitoring Team's findings noted with regard to Section M.1 indicated more entries were found in the IPNs from nursing than during previous reviews, ongoing adequate nursing assessments were not found in the documentation in alignment with the nursing protocols for the particular health issue the individuals were experiencing. Consequently, the additional documentation that was found did not result in an improvement in	Noncompliance

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		clinical care. ▪ Additional information contained in the Facility's Self-Assessment regarding Medication Administration training did not address this specific provision. Although the training was a positive step, it was not clear to the Monitoring Team how these trainings addressed this particular provision. ▪ Although not mentioned in the Facility's Self-Assessment, the Facility's Action Plan addressing this area indicated that promising SOAP (subjective, objective, assessment, and plan) templates addressing the nursing protocols had been developed by the Facility in an effort to implement the consistent use of nursing protocols. However, the documentation contained in the Presentation Book for Section M indicated that: "after evaluation of the template tool between the CNE, the Program Compliance Nurse, and the Nursing Services Coordinator Valerie Kipfer, it was decided that this would be an ineffective tool for assisting with protocol charting methods." However, no specific information was provided regarding the problematic issues that rendered the plan ineffective. In addition, no information was provided regarding what alternative action step(s) the Facility was considering in order to ensure the use of nursing protocols when developing Integrated Health Care Plans to guide the assessment and documentation of nursing care. Consequently, at the time of the review, the Facility's Action Plan addressing this area was not relevant, since most of the action steps addressed the use of this SOAP template, and the action plan had not been revised. <u>Self-rating</u>: 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 as systems to provide and ensure all nurses implement assessments and protocols is not yet fully established. Action Plans will reflect plans to achieve compliance." As noted in more detail with regard to Section M.1, the Facility had experienced significant staffing challenges since the last review that included a complete turnover in the nursing leadership positions. However, as noted above, there was no information provided that specifically addressed how the Facility planned to address moving forward regarding this provision. Although the CNE indicated that since the last review, the State had developed additional nursing protocols, and these had been implemented at the Facility, the Monitoring Team found little to no evidence that they were actually being used. The consistent problematic findings found in the nursing documentation reviewed for Sections M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that	

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		essentially, the same significant problematic issues were found during the current review as was found during the previous reviews. Clearly, the Facility was not implementing nursing protocols sufficient to address the health status of the individuals served. In addition, the major concerns the Monitoring Team had regarding these consistent problematic issues, especially related to individuals with high/medium risk health indicators and their changes in status warranting hospital admissions were exemplified in a review of Individual #149's health care prior to her death from pneumonia in December 2012. Based on the documentation the Facility provided, Individual #149 was noted to have problems that included constipation, falls, osteoporosis, repeated episodes of MRSA, a history of aspiration pneumonia and a Gastrostomy Tube due to aspiration, possible early Alzheimer's, gastritis (mild), Peripheral Artery Disease (PAD), Hypothyroidism, visual acuity deficit, speech defect, and a past fracture of left femoral neck in 8/2011. The Comprehensive Nursing Assessments indicated that she had been experiencing coughing episodes during the past year, as well as an increase in falls and recurrent urinary tract infections. In September 2011, she was hospitalized for low blood pressure, low heart rate, and lethargy, and was found to have a urinary tract infection, dehydration, and a positive MRSA culture to her nose. A review of the documentation found a number of significant problematic issues regarding the care of this individual. Some of these problems included: ▪ In reviewing the documentation for Individual #149, the Facility indicated that: "there is no IRRF as her ISP was not due and the new IRRFs were completed on the ISP dates." Consequently, no documentation addressing her risk indicators was provided to the Monitoring Team. ▪ The summary sections of the Comprehensive Nursing Assessments dated 4/30/12, 7/12/12, and 10/26/12 did not include an analysis regarding the individual's health risks. ▪ The Health Management Plans (HMPs) addressing MRSA, constipation, and Potential for injury from the Active Record contained little to no individualization for an individual with these health risks and were clinically inadequate. ▪ The nursing interventions contained in the HMPs were not in alignment with nursing protocols in that there were no interventions addressing nursing assessments for any of the individual's health risks. ▪ There were no HMPs found addressing PAD, aspiration risk, respiratory issues, Urinary Tract Infections, and falls. ▪ 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,	

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		treatments provided, pain assessments, vital signs, lung sounds, oxygen saturations, bowel and urinary output, daily food and fluid input, assessments for hydration, or bowel sounds and abdominal palpation. ▪ In spite of the documentation in the IPNs on 10/2/12 by nursing indicating that Individual #149 was "coughing so much that her face got red," there was no nursing follow-up assessment conducted and documented until the following day when she was seen by the physician. ▪ There were no regular nursing assessments found documented in the IPNs in response to vomiting episodes that the Individual experienced on 10/10/12 and 11/6/12. ▪ There were no descriptions included in the IPNs of Individual's #149 cognitive functioning and mental status related to her Alzheimer's diagnosis. ▪ There were no IPNs found from the PNMT indicating why her fluids had been changed from thin to thickened fluids. ▪ There were no Dietician IPNs found a month prior to Individual's #149 death. ▪ There was no indication that either the PNMT or Dietician was notified of the vomiting episodes that had occurred in October and November 2012. ▪ There were no regular nursing assessments addressing the individual's health issues in alignment with the assessments required by nursing protocols for an individual with health risks and demonstrating a change in status. ▪ There were no IPNs found documenting when the individual was transported to the hospital. ▪ The last IPN found from 12/7/12 indicated that Individual #149 had been "coughing hard." The IPN indicated that she was coughing but "showed no distress." However, the assessment section of the IPN stated: "inability to breath [sic] related to coughing" and noted her pulse was 105. The note indicated that she would be referred to the clinic in the morning. No other assessments or notes were found. Also, a review of an additional 10 individuals that were admitted to the hospital since the last review (i.e., Individual #258, Individual #136, Individual #6, Individual #209, Individual #181, Individual #317, Individual #35, Individual #74, Individual #147, and Individual #225) found similar problematic issues throughout the nursing documentation as those found in Individual #149's record (more detailed findings are provided with regard to Section M.1). These consistent problematic findings clearly showed that the Facility had not actually implemented the use of nursing protocols as required by the Settlement Agreement. From the Monitoring Team's review, there was no indication that nursing was actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation to ensure that:	

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		▪ 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; and ▪ Appropriate and clinically adequate care plans were developed and implemented that outlined specific nursing interventions for specific health issues. 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 substantial compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	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. In response to this requirement, LBSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ The Facility indicated that 100% of current RN Case Managers received training regarding the Individual Support Plan – At Risk Individuals procedure that included training regarding the Integrated Risk Rating Form and the Integrated Health Care Plan. The Facility also indicated that additional training regarding these areas had been provided to the staff by State Office Discipline Coordinators and/or Consultants, and should be completed by for all staff by September 2013. New Employee Orientation also included a general overview of the ISP process that included the At-Risk process. Training would be tracked through the Competency Training Department. ▪ In the Self-Assessment for this provision, the Facility provided some data regarding the IRRFs. However, the data was uninterpretable since only overall compliance scores were provided. This rendered the data meaningless in determining the items that were problematic as well as noting if any improvements had been made in these items each month. The Monitoring Team has consistently noted in past reports that overall compliance scores do not accurately reflect the specific discipline practices being monitored. Thus, it was unclear to the Monitoring Team why overall compliance scores were reported regarding the monitoring data addressing this provision. This was particularly troubling since the Monitoring Team's findings noted below indicated that essentially no progress had been made addressing this requirement of the Settlement Agreement.	Noncompliance

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		▪ Additional information was included in the Facility's Self-Assessment. However, it did not address the requirements of this provision. Also, no information was included addressing the problematic issues found during the previous reviews related to nursing staff's role regarding this provision of the Settlement Agreement. <u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance because systems to assess clinical indicators of individual risk have not been adequately developed and implemented." Consistent with past reviews, the findings from the Monitoring Team noted below indicated the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of records for 23 individuals determined to be at risk (i.e., Individual #181, Individual #217, and Individual #61 for choking risk; Individual #52, Individual #82, and Individual #74 for cardiac issues; Individual #156, Individual #202, and Individual #51 for behavior issues; Individual #89, Individual #3, and Individual #1 for constipation; Individual #281, Individual #9, and Individual #97 for skin issues; Individual #73, and Individual #75 for weight issues; Individual #130, Individual #171, Individual #128, and Individual #232 for fractures; Individual #113 and Individual #242 for fluid imbalance) found that four (17%) included adequate nursing risk assessments that included individual-specific information that clearly justified the risk ratings assigned (Individual #74, Individual #156, Individual #202, and Individual #51). A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 23 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 health indicators in the Summary Section of the Comprehensive Nursing Assessment form. A review of these 23 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. As noted with regard to Section I, the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms. However, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information from the current year as compared to the previous year that made it difficult to determine the accuracy of the risk rating that was assigned.	

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		Consistent with the findings from previous reviews, the CNE reported that since the previous review, no modifications or specific procedure had been implemented to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments reviewed for the At-Risk individuals noted above did not adequately address their health risks, and in some cases, did not even include all the high/medium health risks in the Summary Section of the Comprehensive Nursing Assessments. In addition, a review of the 23 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%). In addition, 19 individuals (83%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record. Individuals who did not have a related care plan included Individual #217, Individual #52, Individual #51, and Individual #130. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 19 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, 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 adequate fluids, 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 IHCP/Risk Action Plans into the ISPs in 19 of the 23 cases (83%). Individuals who did not have their IHCPs/Risk Action Plans in the Active Record included: Individual #217, Individual #52, Individual #51, and Individual #130. ▪ None (0%) of the plans reviewed 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.	

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		▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability or it was not addressed. At the time of the review, the Facility had begun to implement the additional changes that had been made to the ISP and At-Risk process. 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 interventions contained in the Risk Action Plans, HMPs, and IHCPs still had not been addressed. 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 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.	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, activities addressing this provision included the following: ▪ The Facility's Self-Assessment indicated that a review of the minutes of the Medication Safety and Systems Committee from November 2012 through May 2013 found six of six months (100%) demonstrated that variance reports were submitted from Unit 1, Unit 2, and Unit 3 each month per policy. ▪ Since the last review, from a total of 14 (N) medication variances with a severity score of "C" or greater, the Clinical Pharmacist reviewed 14 (n) of these variances (100%), and based on the information contained in the variance report, scored the event the same as nursing in all (100%) the cases reviewed. ▪ In addition, the Self-Assessment indicated that two corrective action plans were updated and completed. However, no additional information was provided indicating what impact if any they had on the overall medication administration system or their overall significance regarding this provision. ▪ Although the Facility's Self-Assessment indicated that data for the number of returned medications was available by month, by home since October 2010 and were analyzed and graphed, no information was included in the Self-Assessment specifically addressing what trends were identified, what actions had been implemented, and what the effect was of the actions taken. ▪ The Facility reported that beginning in March 2013, unexplained returned	Noncompliance

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		medications were treated as dose omissions and a variance report was completed for each associated individual. Although this was a positive step forward in more accurately assessing the Facility's medication variances, it was unclear to the Monitoring Team why this had not been implemented before March 2013, since the Facility had recognized the issue previously. ▪ For the period November 2012 through April 2013, 3,769 units (pills) of medication have been returned to the pharmacy as unexplained. No further information was provided regarding this finding in the Self-Assessment. Self-rating: Regarding the Facility's compliance rating, the Self-Assessment stated: "based on findings of this self-assessment, this provision is not in substantial compliance because while data is collected and analyzed monthly, no significant improvement in the issue of unexplained returned medications has been achieved." Although the Monitoring Team's findings supported the Facility's Self-Rating of noncompliance regarding this provision, it was unclear to the Monitoring Team from the lack of information contained in the Self-Assessment what the specific findings were from the Facility's trending and analyses activities. Additional information should have been provided in order to fully understand what trends the Facility had identified, and what actions the Facility had implemented, the resulting outcomes, and the Facility's plan for future actions addressing this crucial requirement of the Settlement Agreement. While little information was provided in the Facility's Self-Assessment regarding progress made since the last review addressing this provision, interviews with the Nursing and Pharmacy Departments, and review of the minutes of the Medication Safety and Systems Committee meeting minutes indicated that the following steps regarding the Facility's overall medication administration system had been initiated: ▪ During the previous review, the Facility implemented a system to decrease medication variances related to medications being given to the wrong individual. This included the 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 since the last review, this system had been implemented Facility-wide. Although this was a very positive step forward in the prevention of medication variances that involved administering the wrong individual medications, the Monitoring Team's	

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		observations while on site found that the system was not being consistently implemented during medication administration. ▪ Since the last review, the Pharmacy Department had initiated spot checks audits of the Medication Administration Records and the medication counts across all 15 residences. ▪ In order to reduce the number of unexplained returned medications, the Facility initiated medication count procedure for each shift in six homes. ▪ In addition, the Facility recently had implemented an enhanced charting procedure regarding medications in effort to promote clearer documentation using charting codes. The system should make it easier to determine the reason for a returned medication. Although the steps discussed above included some forward movement, at the time of the review, the Monitoring Team found that LBSSLC continued to have significant problematic issues regarding its overall medication administration system as noted below: ▪ Although the Facility was in the process of implementing a promising system to address medication reconciliation that included medication counts between shifts in six homes to timely identify excess or shortages of medications, the CNE indicated staff that worked in that particular building would conduct these counts. It would stand to reason that the staff in a specific building were the ones generating the unexplained returned medications, so it was unclear to the Monitoring Team why these staff would be the ones assigned to count the medications. The bias that would be innately introduced into this new system would likely render any data generated unreliable. Assigning staff from other buildings or staff from the nursing leadership team to participate in the counts between shifts might add the impartial element needed in order to accurately identify problematic issues. ▪ At the time of the review, no formal tracking system had been 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. The significant number of unexplained returned medications identified and not reconciled quite probably included medications that had not been administered as ordered for the individuals at LBSSLC. The clinical ramifications of this issue could be dire depending on the types of medications that were being returned to the Pharmacy, such as medications prescribed for seizures and constipation. ▪ During past reviews, the Facility repeatedly had identified 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, as a factor	

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		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 experienced by the Nursing Department. ▪ Although the Facility was spending much time reconciling unexplained returned medications, the number of other actual medication variances suggested that LBSSLC continued to have a significant problem regarding the under-reporting of medication variances. ▪ The Facility's data indicated that most of the Medication Administration Observations conducted since the last review were deemed as passing with 100% compliance. However given that the Facility's data showed that 3,769 units of unreconciled medications were identified from November 2012 through April 2013, the high passing rate regarding the Medication Administration Observations was highly suspect. There was no indication at the time of the review that nursing was analyzing these obvious discrepancies between data and practice. A review of the medication variances (Category A-E) reported by the Facility indicated the following (variance data included Medication Administration Record blanks): ▪ December 2012 - 77 variances, (795 returned medications); ▪ January 2013 - 90 variances, (1322 returned medications); ▪ February 2013 – 91 variances, (1061 returned medications); ▪ March 2013 – 445 variances (including medication return "events," (870 returned medications); ▪ April 2013 - 335 variances (including medication return "events," (817 returned medications); and ▪ May 2013 – 346 variances (including medication return "events," (808 returned). Based on observations of medication administration at Sparrow, the following problematic issues were found. Specifically, the nurse did not: ▪ Check the correct positions for the individuals during medication administration. Although the nurses observed looked at the PNMPs before administering the medications, they did not physically check the individuals to ensure they were in the correct position in alignment with the PNMP. When asked about this by the Monitoring Team, it was noted that none of the individuals' observed were in the correct position according to the PNMPs; ▪ Assess lung sounds when an individual demonstrated significant congestion and began to cough during administration of medications; ▪ Did not tell the individuals what medication they were receiving;	

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		▪ Did not provide instructions for positioning after medication administration to the direct support professionals; ▪ Did not consistently check for tube placement prior to medication administration; ▪ The Facility Nurse conducting the medication administration observations did not review the PNMPs to recognize that the individuals were not in the appropriate positions; and ▪ One of the medication carts would not open during the observed medication pass. The nurse administering the medication reported that the cart had been "sticking" for a period of time, but was not aware if it had been reported for repaired or replacement. Since the last review, the Facility clearly had continued to take steps to thoroughly review and implement strategies addressing some of the problematic elements of the medication administration system. However, a number of problematic issues continued to be noted. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as areas of focus/priority for the next six months: As previously recommended, 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 format and structure to critically review 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.	

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 since the last Monitoring Team visit: plans of correction and/or internal auditing procedures and reports related to pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluations (DUE) reports completed since last Monitoring Team 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 (P&T) 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 whether calendar based on fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, for all individuals the Facility serves, 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; o For Quarterly Drug Regimen Reviews two most recent per residential home that have been completed with physician signatures and dates, including for anticholinergic 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; 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; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team 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 "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team visit;

	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 (e.g., 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 (e.g., 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 month for last six months by residence; o Medication history for individuals with jejunostomy (J-tube) or gastrostomy/jejunostomy tube (G/J-tubes) (not G-tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit; o All documentation for each emergency chemical restraint, including restraint checklist since November 1, 2012: o Any trend analysis of chemical restraint use (i.e., 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. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated; o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention

	report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated; o For five new orders in which labs were reviewed/monitored, the following documents were requested: copy of new order, copy of computer screen shot for the initial step of the order, or copy of Medication Administration Record (MAR) reflecting the new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy or copy of MAR reflecting the change in order, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated; o For five new orders for which there was potential for significant side effects, the following documents were requested: copy of new order, copy of initial screen shot processing order or copy of MAR reflecting the new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label or MAR indicating pharmacy processing of change of order. If documents were not available, this was indicated; o For the self-assessment process: list of monitoring/audit tools used and for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/record/table with date range of each database. When the data was collected (i.e., periodically rather than continuously), the frequency of data collection was requested; o Presentation Book for Section N; o Monitoring instructions for spot check audits hand-out; and o Summary of Adverse Drug Reaction Refresher Training June to July 2013. ▪ **Interviews with**: o John Todd, RPh, Clinical Pharmacist; o Billy Bob Beck, Director of Pharmacy; and o Nita Blackburn, CPhT. ▪ **Observations:** o Medication Safety and Systems Committee, on 7/9/13; and o Pharmacy and Therapeutics Committee, on 7/10/13.
	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:

- The monitoring/audit tools the Facility used to conduct its self-assessment included: audit for new order processing, audit for QDRR reviews, and audit for chemical restraints.
- These monitoring/audit tools generally included 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 any additional indicators that are relevant to making compliance determinations.
- The monitoring tools included adequate methodologies, such as record reviews, review of pharmacy data, and review of applicable consultant reports, and polypharmacy meeting minutes.
- The Self-Assessment sometimes 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). These sample size(s) were adequate to consider them representative samples.
- The following staff/positions were responsible for completing the audit tools: Clinical Pharmacist, and Staff Pharmacist.
- Based on their credential, the staff responsible for conducting the audits/monitoring should be clinically competent in the relevant area(s).
- Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools.

- The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate.
- The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:
  - Presented findings consistently based on specific, measurable indicators.
  - Consistently measured the quality as well as presence of items.
  - Distinguished data collected by the QA Department versus the program/discipline.
- The Facility rated itself as being in substantial compliance with the following sub-sections of Section N: N.1, N.2, N.3, N.4, N.5, N.6, and N.7. This was not fully consistent with the Monitoring Team's findings.
- The Facility data identified areas of in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example additional systemic steps to be created for medication variances.

More specific comments regarding some of the components of the Facility's Self-Assessment include:

<u>Section N.1</u>
The Pharmacy Department regularly completed an internal QA review of the new order process. The December 6, 2012 P&T Committee meeting minutes documented that for Section N.1, the pharmacy review of the prior quarter (September 2012 through November 2012) indicated 100 percent compliance, and that the QA inter-rater reliability was 100 percent. The QA Nurse audited a random sample of 20 percent

	of pharmacy drug interventions (i.e., drug interactions, drug allergy alerts, lab interventions, dose range alerts, side effects notification, and other notifications) from the prior month. The QA audit was completed using the active record in the residence to determine whether the pharmacy communicated with the PCP with these various categories of drug interventions. The April 3, 2013 P&T Committee meeting minutes documented that for Section N.1, the pharmacy review for the prior quarter (December 2012 through February 2013) indicated 100 percent compliance. The QA review of the same monitoring tool during this quarter indicated 100 percent compliance, confirming 100 percent inter-rater reliability. The most recent quarter of data also was submitted. For March 2013 (reviewing the drug interventions from February 2013), QA reviewed six interventions. For April 2013 (reviewing the drug interventions from March 2013), QA reviewed 17 drug interventions. For May 2013 (reviewing the drug interventions from April 2013), QA reviewed nine interventions (there appeared to be an irregularity in the datasheet, because there was one "other intervention" for the month, but QA indicated it reviewed three "other interventions"). It was also observed that there were 19 side effect notifications, but that QA had not sampled any of these interventions. Compliance for these three months was 100 percent. Copies of the pharmacy audit monitoring tool and results were provided. Included were monitoring instructions to ensure standardization of the audit process. The tool included two to five indicators for each new order review/intervention. The new order review categories included drug interaction interventions, allergy/disease state contraindication, laboratory interventions, dose rage review, side effect notification, and other category. ▪ For November 2012, there were 109 interventions reviewed (27 drug interactions, zero allergy/disease state contraindications, 12 laboratory interventions, zero dose range concerns, and 70 side effect notifications.) ▪ For December 2012 there were 53 interventions reviewed (14 drug interactions, zero allergy/disease state contraindications, seven laboratory interventions, zero dose range concerns, 31 side effect notifications, and one other intervention). ▪ For January 2013, 108 interventions were reviewed (28 drug interactions, three allergy/disease state contraindications, 10 laboratory interventions, zero dose range concerns, and 67 side effect notifications). ▪ For February 2013, there were 31 interventions reviewed (eight drug interactions, zero allergy/disease state contraindications, seven laboratory interventions, zero dose concerns, and 16 side effect notifications). ▪ For March 2013, 62 interventions were reviewed (17 drug interaction interventions, zero allergy/disease state contraindications, 14 laboratory interventions, zero dose range concerns, and 31 side effect notifications). ▪ For April 2013, there were 39 interventions reviewed (five drug interaction interventions, one allergy/disease state contraindication, 13 laboratory interventions, zero dose range concerns, 19 side effect notifications, and one other category of intervention). ▪ For May 2013, there were 40 interventions reviewed (12 drug interaction interventions, one allergy/disease state, four lab monitoring interventions, 23 side effect notifications, and no dose

	range concerns. It was noted that the pharmacy audit for each month demonstrated 100 percent compliance. <u>Section N.2</u> The December 2012 P&T Committee meeting minutes documented that the internal pharmacy review for the prior quarter (September 2012 through November 2012) provided evidence of 100 percent compliance with Section N.2. The QA inter-rater reliability also indicated 100 percent agreement. The April 2013 P&T Committee meeting minutes documented that the internal pharmacy review for the prior quarter (December 2012 through February 2013) demonstrated 100 percent compliance with Section N.2. The QA monitoring results indicated 100 percent compliance during this quarter, confirming 100 percent inter-rater reliability. The pharmacy tool utilized is described under Section N.3, because the N.2 and N.3 indicators were in one monitoring tool. <u>Section N.3</u> A template entitled: "N.3 Chemical Restraint Checklist, pharmacy monitoring" was submitted, which included six indicators for review (i.e., justification, effectiveness, drug-drug interactions, side effects, review date by pharmacist, and review date by psychiatrist.) To ensure uniformity of monitoring, instructions were created for tracking chemical restraints, including daily and monthly activities to be completed. A completed monitoring datasheet was submitted at the July 10, 2013 P&T Committee meeting using a monitoring tool entitled "N.3 Chemical Restraint Pharmacy Monitoring, Pharmacist Reviews." It reviewed 41 chemical restraints from November 2012 through May 2013. It listed four of the six indicators in the template. (The "Chemical Restraint Tracking" worksheet logged the results of the other two indicators – the date of the Pharmacy restraint review and the date of the Psychiatrist restraint review.) Based on the Facility's data, overall compliance was 86 percent. For the four months of November 2012 through February 2013, the compliance rate using the same instrument was 53 percent. For the month of March 2013, compliance was 94 percent. For the month of April 2013, compliance was 100 percent. For the month of May 2013, the Facility found compliance was 100 percent. The December 6, 2012 P&T Committee meeting minutes documented pharmacy monitoring for the prior quarter (September 2012 through November 2012). Based on the Facility's data, the minutes showed 100 percent compliance with Section N.3. The QA inter-rater reliability also indicated 100 percent agreement. The April 3, 2013 P&T Committee minutes documented that the pharmacy monitoring for the prior quarter (December 2012 through February 2013) demonstrated 100 percent compliance with Section N.3. The QA review for this same time period also demonstrated 100 percent compliance, confirming 100 percent inter-rater reliability. From the information provided, it appeared that QA and Pharmacy reviewed identical charts, and QA reviewed a 100 percent sample of the pharmacy review. For the month of December 2012 inter-rater data, the inter rater reliability was scored as 100 percent, but the data from Pharmacy and Quality Assurance showed some inconsistencies from the monthly data (e.g., there were three responses in the "general" category scored from the QA Department which were entered as "NA"). Although it would appear that this would not significantly change the inter-rate reliability score, the information needed further review and clarity. Similarly, in the N.2/N.3 QA review for January 2013, there was a "Y" response

	from the QA department under the "general" category, which was listed as "NA" in the N.2/N.3 inter-rater comparison review. The Pharmacy Department submitted copies of the monitoring tool and the results of the monthly internal pharmacy reviews. A copy of the N.2 and N.3 Monitoring Instructions was also provided. The monitoring tool used indicators applicable to both N.2 and N.3. Ten clinical indicators were listed. The 10 indicators closely followed the requirements of the QDRR process. Each month, one residence was selected from the list of five homes for which QDRRs were completed during the prior month. Data was submitted for the following months (census for the five residences and census for the one residence is in parentheses): ▪ For November 2012, one of five homes (73 individuals) was chosen for which QDRRs were reviewed for 10 of the 19 in that home (53% of the residents). ▪ For December 2012, one of five homes (63 individuals) was chosen for which QDRRs were completed. A sample of 10 (16%) from one residence was randomly selected (71% of the residence). ▪ January 2013 data indicated that one of five residences (74 individuals) was chosen for which QDRRs were completed. A sample of 10 (14%) from one residence was randomly selected (77% of the residence), and reviewed for each of the 10 indicators. ▪ For February 2013, 10 QDRRs were selected from one of five residences (73 individuals), which was 14 percent of the QDRRs for those five residences and 63 percent of the audited residence. ▪ For March 2013, one of five residences (64 individuals) was chosen for which QDRRs were reviewed for 10 individuals of 11 in the residence (91%). ▪ For April 2013, one of five residences (76 individuals) was chosen for which QDRRs were reviewed for 10 individuals of 18 in that residence (56% of the residence.) Review of these audit results indicated 100 percent compliance for all indicators for all months from November 2012 through April 2013. <u>Section N.4</u> The December 6, 2012 P&T Committee meeting minutes documented that pharmacy monitoring for the prior quarter (September 2012 through November 2012) showed 100 percent compliance, according to the Facility's data. The QA data indicated inter-rater reliability at 100 percent agreement. The April 3, 2013 Committee meeting minutes documented that pharmacy monitoring for the prior quarter (December 2012 through February 2013) demonstrated 100 percent compliance. The QA data also indicated 100 percent compliance for this same time period, confirming 100 percent inter-rater reliability. A sample of the monthly pharmacy monitoring tools was submitted for Section N.4, including a 17-step instruction sheet to standardize the audit process. For each of the homes for which QDRRs were completed, the response from the PCP and psychiatrist was tracked including whether the PCP signed and dated the form, whether there was agreement or not, whether the Psychiatrist signed and dated the form (if applicable), and whether there was agreement or not. A separate monitoring tool tracked the timeliness of each step, from date of pharmacy review, due date of pharmacy review, date sent to the PCP's office, date of PCP review, and date of psychiatry review (if applicable).

	▪ For November 2012, 73 QDRRs were reviewed. ▪ For December 2012, 63 QDRRs were reviewed. ▪ For January 2013, 74 QDRRs were reviewed. ▪ For February 2013, 73 QDRRs were reviewed. ▪ For March 2013, 64 QDRRs were reviewed. ▪ For April 2013, 76 QDRRs were reviewed. ▪ For May 2013, 74 QDRRs were reviewed. It was noted that 100 percent of QDRRs were reviewed for this monitoring tool of Section N.4. For these months, in addition to being 100 percent compliant with each of the four indicators of completion of the QDRR, the Facility indicated there was 100 percent compliance with timely completion of the form through the PCP and psychiatry reviews. The Program Compliance Monitor audited 20 percent of the drug reviews. The review period included the QDRRs completed two months prior to the audit. Of the five residences for which a QDRR was completed during that month, a 20 percent random sample was chosen from each residence. The active records at the residences were audited. The audit reviewed timeliness of review by the PCP and Psychiatrist if indicated, and whether the PCP agreed or not with the recommendation, with a plan of action described if there was disagreement. Timeliness of completion of the QDRR was also reviewed. Timeliness of filing once completed was also tracked. Compliance on each residence from November 2012 through April 2013 was 100 percent. For May 2013, compliance was 99 percent. Copies of the "[Pharmacy] Department and QA Meeting notes for section N" were submitted for 2/21/13 and 3/22/13 at the April 3, 2013 P&T Committee meeting. These documented the findings by the QA Nurse. Minutes of the 2/21/13 meeting indicated that instructions for use of the monitoring tools for N.1, N.2, and N.3 were needed. These were developed by the QA Nurse and discussed on 3/22/13. The 3/22/13 notes indicated that inter-rater reliability data was needed for Section N.4. Additionally, both meetings discussed that the monitoring tools needed validation to ensure that all areas of the subsections were covered. At the July 10, 2013 P&T Committee meeting, "Department and QA Meeting Notes for Section N" were submitted for 4/25/13 and 5/28/13. A QA review utilizing the tools for N.1, N.2/N.3 and N.4 indicated 100 percent compliance (the month was not indicated but it was assumed to refer to March 2013). Monitoring by the Pharmacy Department using these tools indicated 100 percent compliance. The notes indicated that analysis of the tools had been completed and it was agreed by the QA Department that the tools were adequate and measured all areas of clinical concern. The process for inter-rater reliability for N.4 had not been finalized. The 5/28/13 notes indicated that the QA monitoring using N.1, N.2/N.3 and N.4 monitoring tools demonstrated 100 percent compliance (presumably for April 2013). Pharmacy also audited using the same tools, and showed 100 percent compliance.
	Summary of Monitor's Assessment: The Pharmacy Department had continued to provide quality services in a number of areas, and had been a valuable participant in assisting other departments (i.e., the Medical,

	and Nursing Departments). QDRRs remained current. New orders were processed efficiently and with quality reviews prior to dispensing. There had been professional staff training on adverse drug reactions, and drug utilization reviews were completed in a timely manner and appeared to be helpful to the clinical practice of the PCPs. The Pharmacy Department had continued to provide technical support and increased monitoring in attempting to reduce the unexplained returned medications. This remained a challenge, because the problem remained unresolved. In reviewing the appropriateness and safety of polypharmacy, a review of drug-drug interactions would be appropriate. In addition, the chemical restraint forms should have sufficient information to guide staff in analysis and decision-making. The Monitoring Team found the Facility to be in compliance with Sections N.1, N.2, N.4, N.5, N.6, and N.7. The Facility had found it was in compliance with Section N.3, but the Monitoring Team's findings did not support this. The Monitoring Team also found the Facility was in noncompliance with Section N.8, which was consistent with the Facility's finding in its Self-Assessment.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Pharmacy Department staffing included the following: a Director of Pharmacy (RPh), two staff pharmacists (one RPh, and one PharmD), a clinical pharmacist (PharmD), and two pharmacy technicians (RCPht). The Pharmacy Department indicated there were no new policies or procedures that had been implemented since the Monitoring Team's last visit. Although not related to compliance with the Settlement Agreement, on 4/18/13, a state regulatory survey was completed. The information reviewed indicated pharmacy services were part of the deficiencies/conditions identified. These included the lack of labeling of tubes, inhalers, and other small containers. The pharmacy had labeled the box in which they were originally stored, but this was removed while in the medication room. Additionally, a number of medications and other outdated pharmaceuticals were found in the medication rooms. A corrective action plan was accepted and completed. The pharmacy implemented a process in which the actual vehicle (e.g., tube, inhaler, dropper bottle) was labeled rather than the box or container in which it was packaged. If the label was subsequently removed, it was to be returned to the pharmacy. To resolve the problem of outdated medication, the Pharmacy Department was to complete monthly medication room audits to ensure there were no unlabeled medications. The RN Case Managers were to utilize a medication room survey tool that included a review to ensure there were no outdated medications, outdated over-the–counter-medications, or discontinued medications.	Substantial Compliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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"Patient intervention" entries for new orders entered into the WORx software program were submitted for review, as well as a document entitled "Interventions from 4/15/13 through 6/15/13." The following provides the number of patient intervention entries generated per month. Interventions were broken down into several different categories:
<table>
<tr><th>Category of intervention</th><th>April 2013</th><th>May 2013</th><th>June 2013</th></tr>
<tr><td>Adverse drug reaction</td><td>5</td><td>11</td><td>0</td></tr>
<tr><td>Allergy/disease state contraindication</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Drug information (lab monitoring)</td><td>3</td><td>4</td><td>2</td></tr>
<tr><td>Therapeutic Consultation (side effect communication)</td><td>19</td><td>24</td><td>0</td></tr>
<tr><td>Total = 69</td><td>27</td><td>40</td><td>2</td></tr>
</table>
A review of the content of the patient intervention entries was completed. The patient intervention entries included the name of the medication, the dosage when necessary, the clinical concern, and the response from the PCP concerning the plan/next step, as part of the evidence of the new order processing.

A sample of 31 new prescriptions was reviewed. The following summarize the results:

Ten new orders were submitted in which the pharmacy found concerns with drug-drug interactions with the current drug regimen. A copy of the order was submitted in 10 of 10 (100%). 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 change in the order occurred in two orders (change in time of administration only) and no change in eight orders was documented. Based on this information, adequate documentation of the new order process for drug-drug interactions occurred in 10 of 10 (100%) submitted orders.
Five new orders were submitted in which allergies were reviewed and determined by Pharmacy to be a concern. A computer screen shot of the order was submitted for five of five (100%). A copy of the patient intervention was submitted in five of five (100%). As a result of the pharmacy review, there was a documented change in order for one order. There was confirmatory documentation of no change for four orders. Based on this information, adequate documentation of the new order process for allergies occurred in five of five (100%) submitted orders.
Five new orders were submitted in which significant side effects were reviewed by pharmacy and determined to be a concern. A copy of the order was submitted in five or five (100%). An initial screen shot, pharmacy label, or copy of MAR indicating the order was processed was submitted in five of five (100%).

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		A patient intervention note was submitted for five of five (100%). There was no change in order for any of the five. Proof of no change was indicated in a document entitled "PCP communication form" and/or documented in the patient intervention note in all five. A copy of the Micromedex handout was provided in four of five (80%) new orders. Based on this information, adequate documentation of the new order process for communication of significant side effects occurred in five of five (100%) submitted orders. ▪ 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 order was submitted in five or five (100%). A copy of the screen shot, MAR, or pharmacy label was submitted in four of five (80%). A copy of the patient intervention was submitted in five or five (100%). Verification of lab results reviewed by pharmacy was submitted for five or five (100%). Copies of orders for follow-up tests were submitted in four of five. Based on this information, adequate documentation of the new order process for review of significant lab occurred in five or five (100%) submitted orders. ▪ Six new orders were submitted in which pharmacy had concerns about the potential need for **dosage adjustments**. For six of six (100%), a copy of the order was submitted. For six of six (100%)orders, there was a copy of the screen shot submitted. A copy of the patient intervention was submitted in six of six (100%) orders. Documentation of communication was submitted in six of six (100%). There was no change in orders for six of six (100%). Based on this information, adequate documentation of the new order process for review of dosage adjustments occurred in six of six (100%) submitted orders. The Facility remained in substantial 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 schedule of completed QDRRs was submitted from June 2012 through May 2013. Two documents were submitted, a chart entitled "Quarterly Drug Review Date Comparison" (updated 6/10/13), and as confirmation of this information, the audit results of the "QDRR Review Monitoring for the month" (July 2012 through June 2013). Each of the prior QDRRs was reviewed for date of completion and compared to the QDRR due date for completion. For timely completion, the agreed upon time period was based upon a due date of 90 days after the prior QDRR (i.e., the due date listed by the Pharmacy on the monitoring document), with additional parameters established as a time period of seven days prior to the due date through 13 days after the due date. A total of 213 individuals were listed. This would require 852 (213 x 4) QDRRs in a calendar year. Of these 852, 841 (99%) were completed during this window of time. Eleven were completed earlier than the cut off of seven days prior to the due date. A schedule of QDRR completion across the Facility was submitted. Five residences were	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		reviewed in January, April, July, and October of each year. A second set of five residences was reviewed in February, May, August, and November of each year. A third set of five residences was reviewed in March, June, September, and December of each year. At each review, the prior three months' medication information was reviewed for the QDRR. For instance, when a residence was reviewed for the month of January, the prior three months of information (i.e., October, November, and December) was reviewed in completion of the QDRR. A sample of 30 QDRRs was reviewed. The following summarizes the results of this review: ▪ Laboratory information was submitted in 30 of 30 (100%) QDRRs. ▪ 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), as appropriate, in 30 of 30 (100%) QDRRs. ▪ Thirty of 30 (100%) QDRRs had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab and/or in the recommendations section. ▪ Comments and recommendations based on lab values appeared appropriate for 28 of 30 (93%) QDRRs. Two concerns did not appear to be addressed in the pharmacy review. For Individual #147, the potassium level was at the upper limit of normal. Two medications being prescribed had the potential to cause hyperkalemia, but this was not mentioned in the document. For Individual #165, the QDRR stated that thyroid testing was recommended annually, based on medications prescribed, but the last value provided was 9/30/10. There was no recommendation for an updated lab value. ▪ The lab testing completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Pharmacy Department monitored timeliness of QDRR completion by a "twelve month rolling QDRR date tracking" log, which included additional notes if an individual was a recent admission, transferred to the community, or transferred between buildings. All individuals and all residences were tracked. The Facility remained in substantial compliance with this provision.	
N3	Commencing within six months of the Effective Date hereof and with	This provision of the Settlement Agreement encompasses a number of requirements. Each is discussed below, including the Pharmacy, Psychiatry, and Medical Departments'	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 35 chemical restraints used from 11/3/12 to 4/19/13. The chemical restraint documentation indicated that nine individuals had 35 chemical restraints during this time period. Additionally, it was noted during the July 10, 2013 P&T Committee Meeting, that six chemical restraints were utilized in May 2013 for which documents had not been forwarded for review. An additional note from the Clinical Pharmacist, dated 6/10/13, documented that one additional individual was no longer listed in the database since the individual had been discharged from the Facility, and the database automatically removed that event. This chemical restraint occurred on 3/11/13. However, on reviewing the submitted documents, it was included in the scanned documents. For the 35 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 35 chemical restraint forms, 35 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in 20 out of the 35 (57%) chemical restraint forms completed. ▪ Side effects/adverse effects/drug-drug interactions were noted in all (100%) of the completed chemical restraint forms. ▪ There were 10 statements that were considered recommendations. ▪ The range of time for completion of the forms was from one to 17 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 35 completed, there were 35 (100%) forms on which the psychiatry comment section was completed. ▪ For 21 (60%) of the chemical restraints, there was a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For 35 of 35 (100%), clinical justification was documented. ▪ For six of 35 (17%) chemical restraints, comments were made regarding whether there had been changes made or recommendations for changes concerning maintenance medication, the BSP, or environmental factors.	

#	Provision	Assessment of Status	Compliance
		▪ Side effects/drug-drug interactions were mentioned in 35 of 35 (100%) of the reviews. ▪ Effectiveness was documented in three (9%) cases. ▪ The time to completion of the chemical restraint by the Psychiatrist ranged from one to 17 days. As a general observation, more detail from both the Pharmacy and Psychiatry Departments was needed in completion of this interdisciplinary form. More details of significant side effects and drug-drug interactions would assist in determining the risk of use and guide the IDT in further decision-making. Recommendations by the Psychiatrist should provide sufficient detail to guide the IDT in determining adequacy of treatment or need to amend the treatment. Psychiatry provided few recommendations concerning changes in maintenance medication, changes to the BSP, or changes in the environment. If changes in the medication, dosage, or route of administration of a chemical restraint is recommended, this should be clearly described, along with rationale. A brief review of antecedent behavior and team response would assist in determining if the BSP was correctly followed. If the behavior escalated to the point of potential harm, the chemical restraint might have been justified at the time (despite not following the BSP), but the event might have been prevented had the BSP been followed appropriately. As appropriate, the Psychiatrist's review should have reflected this finding and included a recommendation for the need for training or other steps to be taken. If the BSP was followed and was not successful, then a comment from the Psychiatrist should recommended a review and revision of the BSP. Trend analysis was provided through graphs and pie charts. A graph was submitted entitled: "Behavioral Chemical Restraints, FY 2013 to Date (Sept-April) N=37." This indicated the number of chemical restraints per month and the number of individuals with a chemical restraint per month. The information is listed in the following table: **Month** / **# Chemical Restraints** / **# Individuals with a Chemical Restraint** September 2012 / 1 / 1 October 2012 / 1 / 1 November 2012 / 2 / 2 December 2012 / 1 / 1 January 2013 / 2 / 1 February 2013 / 4 / 2 March 2013 / 23 / 6 April 2013 / 3 / 3	

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		The pie chart documented that for the time period September 2012 through April 2013, one individual was administered 14 chemical restraints, one individual was administered seven chemical restraints, one individual was administered six chemical restraints, one individual was administered three chemical restraints, one individual was administered two chemical restraints, and five individuals were administered one chemical restraint. Through a collaborative effort of Psychiatry and Pharmacy, a workgroup was created to develop a routing and review database to monitor chemical restraint use. One of the chemical restraint face-to-face forms in 2012 was filed in the record prior to completion by Pharmacy and Psychiatry, and it was identified that the process needed review to prevent a recurrence. The initial discussion for the workgroup was documented in the December 6, 2012 P&T Committee meeting minutes. A follow-up of the workgroup activity was documented in the April 3, 2013 P&T Committee minutes. The monitoring process developed included the Psychiatric Assistant logging each chemical restraint, the date of review by psychiatry, and the date of review by pharmacy. The new tracking log would be included as part of a monthly monitoring tool for timely completion by the Pharmacy and Psychiatry Departments. The "Chemical Restraint Tracking Sheet" documented the date of restraint, the date of notification of the restraint, the medication name, dose, and route, and date of signature by pharmacy and psychiatry. The guideline for timely review followed a policy entitled "Positive Behavior Support: Limitation of Restraint," in which it stated: "The pharmacist and psychiatrist must conduct a clinical review of each chemical restraint used in response to a behavioral crisis… this review is completed within 10 working days of the application of the chemical restraint…" Timeliness was tracked, and data from the month of May 2013 was submitted. For this month, the average number of working days from the date of restraint to Pharmacy review of the chemical restraint was 3.67 days. For this month, the average number of working days from the date of restraint to Psychiatry review of the chemical restraint was 2.83 days. <u>Polypharmacy</u> Of the 30 QDRRs reviewed, polypharmacy was noted in 16 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 16 of 16 (100%) QDRRs. ▪ Clinical justification for the use of polypharmacy was addressed in 16 of 16 (100%) QDRRs. For justification of polypharmacy, copies of documents supporting the use of polypharmacy (i.e., annual medical assessment entries, neurology consults, monthly polypharmacy meeting minutes) were attached to the QDRR for review as evidence of justified polypharmacy. ▪ Potential side effects were reviewed in 16 of 16 (100%) QDRRs. However, when the statement was made of no side effects in some cases, this might not have	

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		been accurate. It might have been a more accurate statement that the side effects were treated or did not impact the individual. For instance, Individual #171 was reported to have "no side effects noted." However, the ammonia level was increased and required administration of Lactulose to reduce the level. Individual #290 was prescribed five medications for seizure control and additional rescue medication as well as three medications for allergies. The QDRR indicated: "no side effects noted." It would appear that PCP and consultant notes might not address specifically whether side effects are present or if present, are well controlled or do not affect daily activity. A review of neurology consult forms indicated side effects were documented as present or not in six of 13 records reviewed (as discussed with regard to Section L1). The lack of documentation might not indicate lack of side effects unless the PCP, consultant, nurse, habilitation therapist, or other health professional indicates this information specifically. Otherwise, in such cases, these documents cannot be used as evidence verifying no side effects. The Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: This issue should be discussed with the Medical Department to determine accurate assessment and documentation of side effects in those with polypharmacy, and if there are no side effects, to ensure there is lab data to verify this when indicated (e.g., ammonia levels if appropriate), or written documentation of lack of side effects, or whether side effects are sufficiently treated (e.g., minimizing drooling with medication). ▪ Potential interactions with other drugs or food was reviewed in five of 16 (31%) ▪ For 16 of 16 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. Polypharmacy also was also documented through the P&T Committee meeting minutes. At the 12/6/12 meeting, the Psychiatrist reviewed the results of the September through November 2012 data. Of 121 individuals on psychoactive medications, 16 individuals with greater than one year of residence at the Facility had stable polypharmacy, and eight individuals with greater than one year residence at the Facility had active polypharmacy, as of the November 2012 data. Four individuals with residence of less than one year at the Facility had polypharmacy. At the 4/3/12 P&T Committee meeting, it was noted that there were 124 individuals on at least one psychoactive medication. Ten individuals with greater than one year of residence at the Facility had active polypharmacy, and 16 individuals with greater than one year of residence at the Facility had stable polypharmacy, as of the February 2013 data. Seven individuals with residence of less than one year at the Facility had polypharmacy. At the July 10, 2013 P&T Committee meeting, it was noted that there were 126 individuals on at least one	

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		psychoactive medication, as of May 2013. Seven individuals with greater than one year of residence at the Facility had active polypharmacy, and 17 individuals with greater than one year of residence at the Facility had stable polypharmacy. Five individuals with residence of less than one year at the Facility had polypharmacy. A monthly Facility Polypharmacy Meeting monitored psychotropic polypharmacy use. This is discussed in greater detail with regard to Section J.8. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 12 of the 30 QDRRs. ▪ Of these, 12 of 12 (100%) documented justification with appropriate diagnoses. ▪ Twelve of 12 (100%) QDRRs indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 30 QDRRs, 30 (100%) were screened for medications associated with potential significant anticholinergic side effects. Ten QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 10 of 10 (100%) of cases with this medication prescribed. ▪ Ten of 10 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect, and the clinical burden of the side effects was less than the benefit. ▪ Ten of 10 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 30 QDRRs reviewed, 15 listed atypical antipsychotic medication. Of these, 15 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel, as appropriate). The Facility remained out of compliance with this provision. Although many of the requirements of this provision had been met, the quality and comprehensiveness of the Pharmacy and Psychiatry Departments' review of chemical restraints required improvements. In addition, in completing the QDRRs related to polypharmacy, attention should be paid to the documentation of the presence or not of side effects, and potential interactions of medications with other drugs or food.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the	Review of 30 QDRRs showed the following: ▪ Of the 30, 30 (100%) QDRRs had the PCP signature. ▪ Of the 30, 30 (100%) QDRRs had the date the PCP reviewed the document. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 30 of 30 (100%) QDRRs.	Substantial Compliance

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	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.	○ Agreement was documented in 28 out of 30 QDRRs. ○ There was disagreement by the PCP for two QDRRs. ▪ For two of two (100%), a note of justification and plan was recorded on the QDRR. ▪ The PCP responded within 14 days of the QDRR being completed by Pharmacy in 30 of 30 (100%) QDRRs. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. ○ A Psychiatrist reviewed and signed 21 of the 30 applicable QDRRs (100%). ○ Agreement was documented in 21 of 21. ○ Disagreement with justification and plan was documented in zero out of 21. ○ The Psychiatrist responded within 14 days of the QDRR being completed by pharmacy in 21 of 21 (100%) QDRRs. To determine if the recommendations agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. In the sample of 10, 10 (100%) demonstrated that the PCP/Psychiatrist acted upon the recommendation. Lab values were obtained following the review of the QDRR with the recommendation. The Facility submitted six active records in which recommendations from the QDRR were not followed. In six of six (100%) cases, the response, rationale, and plan were written on the QDRR. The Facility remained in substantial 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 requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale (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 (per the Healthcare Guidelines). 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 the Monitoring Team's previous reports, the Psychiatry Assistant had undergone specific training on how to administer the DISCUS examination.	Substantial Compliance

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		The review of the sample of the records for 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 (100%) individuals. 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 (100%) of these individuals. 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 (100%) of these individuals. The prescribing practitioner had reviewed and signed all (100%) of the completed DISCUS evaluations in the sample records within 14 calendar days of completion. The DISCUS and MOSES also were 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 six of the 22 (27%) individuals fitting the above criteria was selected: Individual #312, Individual #199, Individual #281, Individual #308, Individual #135, and Individual #324. The review of the records of these individuals indicated that the MOSES evaluations had been performed as required for all (100%) of these six individuals. The documentation had also been reviewed and signed by the prescriber in a timely manner for all six (100%) individuals. The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated these evaluations were completed as specified for five of the six (83%) individuals. Individual #308 was missing documentation, because only one DISCUS evaluation (dated 5/12/13) could be located in the record. The prescribing practitioner also had uniformly reviewed and signed these evaluations in a timely manner for all (100%) of these individuals in the sample. The review of the overall completion rate of the MOSES every six months, as specified in	

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		the Settlement Agreement, indicated these evaluations had been carried out as specified for all (100%) of the individuals in the overall sample of 19 individuals receiving psychotropic medication, as well as all six (100%) individuals prescribed Reglan who were in the sample of individuals prescribed Reglan and were also not receiving any psychotropic medication. The assessment of the timely review of these documents by the prescriber indicated that the review had been completed within 14 days for all (100%) of the individuals in the sample of 19, and all (100%) of the six individuals in the sample who were receiving Reglan. A similar analysis of the assessments related to the administration of the DISCUS every three months indicated that they had been performed as specified for all (100%) of the 19 in the sample of 19 individuals. The corresponding analysis of the timely signature of these also indicated a 100 percent completion rate. The corresponding rates for the Reglan sample indicated that five of the six (83%) individuals had the DISCUS performed every three months. The record with missing documentation was for Individual #308, for whom only one DISCUS could be located, which was dated 5/22/13. The combined rate for the completion of the DISCUS, including both samples, would be 24 of 25 (96%). These uniformly high rates of completion indicated the Facility had developed and maintained a system to routinely ensure side effect monitoring tools were completed, as specified in the Settlement Agreement. This resulted in the finding that the Facility remained in substantial compliance with 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.	The Pharmacy Department submitted a document entitled "Summary of Adverse Drug Reaction Refresher Training June – July 2013." In this document, the Pharmacy Department indicated that there were 85 nurses employed at LBSSLC as of July 3, 2013. The document indicated that 80 had completed a refresher, training course or new employee orientation since January 2013. The Pharmacy Department calculated a training completion rate of 94 percent. A sample of the post-test for "Adverse Drug Reaction Reporting" was also submitted. Ten rosters were submitted, documenting that pharmacy completed training on ADRs for nursing staff, with a date range of 6/24/13 through 7/3/13. Additionally, the Nurse Educator completed new employee nursing orientation, which included adverse drug reporting. These trainings occurred on the following dates: 12/21/12, 2/22/13, 3/25/13, 4/3/13, 4/22/13, 5/8/13, 5/20/13, 6/21/13, and 6/27/13. Matching names from these rosters to the departmental nursing staff list dated 6/25/13 confirmed 80 names on the departmental list had been trained. Several names had duplicate signatures on different training rosters, and training credit was only given once per	Substantial Compliance

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		nurse. There were an additional eight nurses trained for whom the names appeared similar but not identical (i.e., different first names), or were illegible. The total number of nurses trained on adverse drug reactions was 88. Although the Monitoring Team could not confirm the pharmacy data that 80 of 85 nurses were trained in ADRs, it appeared that more training had occurred. Eighty-eight instead of 80 nurses. This appeared to equal or exceed the 94 percent calculated by the Pharmacy Department. It was noted that the nursing staff list was dated 6/25/13, and there were nurses trained after this date. There was the notation that the Pharmacy Department calculated training completion as of January 2013 onward, but there was one submitted roster from 12/21/12. In addition, nurses that had been trained during this time period could have left and the Pharmacy Department had used a list of nurses employed as of July 3, 2013. These minor variations might have contributed to the difference in numbers between the Pharmacy Department and Monitoring Team's analysis. Additionally, the Pharmacy Department trained 11 staff from the Medical, Psychiatry, and Pharmacy Departments on "Adverse Drug Reaction Reporting" (dates of training from rosters were 5/9/13 and 5/14/13). There were two names duplicated on the rosters and the additional signatures were removed in determining the number trained. This was a 100 percent training rate for PCPs and full-time psychiatrists on staff. From the minutes of the December 6, 2012 P&T Committee meeting, it was noted that there was ongoing training for direct support professionals and training occurred for 100 percent of both direct support professional and nursing staff. The Facility submitted an "Active Employee Course Participation Report" for completion of "Observing and Reporting Clinical Indicators of Health Status" during orientation in-services for residential direct support professionals, psychology, nursing, vocational services administration, day programs, physical/nutritional management, and other departments at LBSSLC. There were 576 names listed as having completed the training from 2011 through 2013. Of these, 137 completed this course since October 1, 2012. As an ongoing reminder, posters and signage were located in the residences identifying signs and symptoms for which a direct support professional should contact a nurse. The December 6, 2012 and April 3, 2013 P&T Committee meeting minutes documented that there were no reported adverse drug events in the prior fiscal quarter. The Facility remained 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	A drug utilization evaluation calendar was submitted for the fiscal year 2013-14. This included the following topics:	Substantial Compliance

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	performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<table><tr><th>Month</th><th>Topic</th></tr><tr><td>September 2013</td><td>Metronidazole</td></tr><tr><td>December 2013</td><td>Lithium</td></tr><tr><td>March 2014</td><td>ACE Inhibitors</td></tr><tr><td>June 2014</td><td>Haloperidol</td></tr></table> During the prior six months, two DUE studies were completed: ▪ A DUE was completed on Reclast and presented at the 12/6/12 P&T meeting. Included in the review were indications for use, contraindications for use (e.g., renal function determined by calculation of creatinine clearance, history of hypersensitivity to the medication, and hypocalcemia), precautions or warnings for monitoring (e.g., dental screening prior to use, serum creatinine obtained within 30 days of administration, creatinine clearance calculation prior to administration, and creatinine clearance adequate for administration), and other clinical monitoring indicators (e.g., annual Vitamin D level, serum calcium level reviewed, Vitamin D prescribed, calcium intake calculated from both dietary and prescribed supplements, and nursing post-administration monitoring.) Findings indicated compliance in all areas except for dietary and supplemental calcium intake. The report documented "in three individuals, it was found that no additional supplementation of calcium was ordered. While ordered dietary content is adequate, there can be variation in daily meal consumption which could result in insufficient calcium intake at times." These three individuals were subsequently ordered supplemental calcium. Due to these findings, a revised protocol for Reclast was approved, with two additions, in order to provide a check/balance for calcium when preparing for Reclast review and administration. These steps included: "At the same time, PCP reviews the patient medication profile and verifies that supplemental calcium and Vitamin D is ordered for the individual," and "PCP may request a dietitian consultation regarding total dietary and supplemental calcium required, if indicated." These added steps occurred in the "Reclast/Prolia Process Steps" after "PCP writes order for Reclast or Prolia Administration." This DUE had significant clinical impact in amending the protocol for Reclast and Prolia use based on findings of the review. ▪ A DUE was completed on Levofloxacin usage on 3/27/13. A review was conducted of new orders in which indication for usage was reviewed [Federal Drug Administration (FDA) labeled indications were used as criteria], contraindication of usage, and monitoring precautions or warnings were reviewed (i.e., rash, gastrointestinal side effects, neurological side effects,	

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		preexisting cardiac conditions such as prolonged QT interval, and increased seizure activity). Results were presented at the 4/3/13 P&T meeting. Sixteen new orders were reviewed, and there were no findings needing further follow-up. No trends were identified. At the time of the Monitoring Team's visit, an additional DUE was reviewed. The results of the Olanzapine DUE were discussed at the July 10, 2013 P&T Committee meeting. A 34 percent sample of those prescribed Olanzapine was included in the review. Indicators reviewed included indications for use, contraindications for use, precautions requiring monitoring (e.g., blood glucose or Hgb A1C, lipid panel, electrocardiogram, hepatic function, review of cardiovascular risk), and other specific monitoring such as Body Mass Index (BMI), current MOSES and DISCUS completion, and use of anticholinergics or benzodiazepines for side effects of olanzapine. For these 13 indicators, there were no areas of non-compliance. According to the Pharmacy Department, there were no follow-up studies required for completed DUE reports during this time period. The Facility remained in compliance with this provision.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.	<u>Pharmacy Review of Categorization of Errors</u> 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 April 24, 2013 Medication Safety and Systems Committee (MSSC) minutes recorded a review of medication variances from January 2013 and February 2013 for variances the Nursing Department categorized as C or greater. This totaled eight variances from January 2013 and six variances from February 2013. Nursing had categorized these as 13 Category C and one Category D. The pharmacy pulled the medication variance reports, scored the variances according to National Coordinating Council for Medication Error Reporting and Prevention (NCC-MERP) guidelines and current medication policy. Agreement was 100 percent. <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 MSSC meetings, which the Clinical Pharmacist chaired. The following describes some of the findings of this committee: ▪ The November 14, 2012 MSSC minutes documented that the identification (ID) cards of the individuals were in place for medication passes on only two residences. This was to reduce administering medication to the wrong individual. It was noted there were some difficulties, but that the Nursing	Noncompliance

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		Department and Residential Services were collaborating to resolve these concerns. The Pharmacy completed four medication audits in October and four in November. Medication variance reports for October 2012 indicated that there were 84 variances from all three units. There were 74 blanks left in the MAR (i.e., documentation error), and six were noted to be dosage omissions. To reduce documentation errors, face-to-face MAR audits were completed at shift change. The unexplained, returned medications were 124 for Unit I, 383 for Unit II, and 387 for Unit III, for a total of 894 unexplained returned medications. ▪ The December 20, 2012 MSSC minutes documented that the ID card program had been successfully implemented in two residences, and was being expanded to a third. According to Facility data, monitoring of the direct support professional participation in the medication pass process indicated 87 to 100 percent compliance. For November 2012, medication variances for the three units totaled 39, with 13 due to documentation errors of MAR blanks, 12 due to incorrect dose, and nine due to true omissions. The unexplained returned medications were 105 for Unit I, 218 for Unit II, and 268 for Unit III, for a total of 591. ▪ The January 23, 2013 MSSC minutes documented the ID card program had been completed in three residences and was expected to be expanded to all residences by May 2013. The Nursing Department was monitoring a medication pass on Canna home monthly, and on Quail and Sparrow on a weekly basis. Pharmacy completed a spot check in one residence. For December 2012, medication variances for the three units totaled 77, including 65 documentation errors and nine dose omissions. The unexplained returned medications were 302 for Unit I, 232 for Unit II, and 261 for Unit III, for a total of 795. ▪ The February 27, 2013 MSSC minutes documented RN Case Managers assumed the monitoring of medication passes with observation of the direct support professionals' role. An enhanced recording process was to be implemented on March 1, 2013. The use of symbols and codes was designed to improve accuracy of documentation for a missed medication. For January 2013, medication variances for the three units totaled 90, including 82 documentation errors involving MAR blanks. There were five omissions. The unexplained returned medications were 377 for Unit I, 561 for Unit II, and 384 for Unit III, for a total of 1,322. ▪ The March 20, 2013 MSSC minutes documented that in February 2013, medication variances for the three units totaled 91, including 85 documentation errors, five dose omissions, and one wrong patient. The severity scorings from September 2012 through February 2013 were reviewed. There were 417 events scored as category A, six were category B, 60 were category C, and two were category D. The unexplained returned medications for February 2013 were 348	

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		for Unit I, 306 for Unit II, and 407 for Unit III, for a total of 1,061. Data for fiscal years 2011, 2012, and the first six months of fiscal year 2013 were reviewed, and indicated no progress in reducing the numbers. ▪ The April 24, 2013 MSSC minutes documented that the ID cards for each residence had been completed, and the next step was to provide in-service to the staff. Facility staff reported that previously mentioned introduction of a coding system for charting procedures was providing more accurate results, and the audits were completed in less time. This was found to be similarly helpful to the spot check audits completed by Pharmacy. The March 2013 medication variance data reflected the administrative change of reporting unexplained medication returns as omission variances. An in-service was presented focusing on reading and interpreting the manufacturers' dating of drugs. This was in response to the Intermediate Care Facility (ICF) survey results. This was to be given to the nurse as they arrived at the Pharmacy. Pharmacy did spot check audits on eight residences. A report was provided concerning the monitoring of residential staff during medication passes. According to the Facility's data, compliance was 92 to 100 percent. For the month of March 2013, medication variances for the three units totaled 445, including 80 documentation errors, 10 dose omissions, and 345 unexplained returned medications (i.e., defined as events and not individual tablets/unit doses). There were 870 unexplained returned medication doses. MAR reviews by Nursing, as well as shift change reviews by Nursing had been discontinued. ▪ The May 30, 2013 MSSC minutes documented that the ID card system remained in the implementation phase. Nursing Administration had chosen six residences to begin counting medications each shift, but this had not been implemented at the time of the committee meeting. MAR checks by Nursing was reinstituted, and included not only checking for MAR blanks, but also whether the new coding procedures were being followed for medications not administered. Pharmacy, in response to a recent ICF survey, had begun to label bulk medication tubes/containers, and not the storage box. In-servicing of Nursing, concerning reading and interpretation of medication expiration dates, had occurred. During April 2013, all 15 residences had spot check audits by Pharmacy. For April 2013, there were a total of 335 medication variances for the three units, including 226 documentation errors, and 108 unexplained returned medication events. There were 201 returned medications from Unit I, 392 returned medications from Unit II, and 224 returned medications from Unit III, for a total of 817 returned medications for the month of April 2013. ▪ The July 9, 2013 MSSC included several handouts and reports that were reviewed. Pharmacy spot check audits were completed in all 15 residences for the month of May 2013. In each home, three or four MARs for individuals were	

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		reviewed along with medication counts. This represented 18 to 33 percent of individuals in each residence. Based on the Facility's data, compliance by home varied from zero to 100 percent. Four residences had zero percent compliance. Four residences had 25 percent compliance. One residence had 50 percent compliance. Three residences had 75 percent compliance, and three residences were 100 percent compliant. A document entitled "Review of Residential Medication Pass Observations meeting minutes, dated 6/26/16 [sic]" was submitted at the 7/9/13 committee meeting. This documented observation of direct support professionals according to the monitoring tool that focused on medication pass processes and roles of the residential staff. Compliance ranged from 82 to 100 percent. For the month of May 2013, there were a total of 346 medication variances for the three units, including 146 documentation errors, and 200 unexplained medication return events. For May 2013, there were 808 returned medications. A document was submitted entitled "Procedure to Count Medications each shift," with implementation date of July 2013. This provided each step of the process to be used in the six pilot residences. Dated 6/28/13, a document was submitted entitled "Synopsis of Activity since the previous monitor visit, provisions M.6 and N.8." In bullet format, this provided a summary of involvement by the Pharmacy Department in efforts to improve the medication variance rate at LBSSLC. This list included the following initiatives: ▪ Identification of the individual via an ID card in all residences at time of medication administration. This required collaboration with the residential staff. ▪ A monitoring tool to observe the role and effectiveness of residential staff in ensuring each individual received the correct medication pass. ▪ Unexplained returned medications were categorized as omissions as of March 1, 2013. ▪ Improved clarity in documenting reasons on the MAR for not administering medications. ▪ Initiation of unannounced spot check audits of MARs and medication counts in all residences. ▪ Counting medications each shift piloted on six residences. ▪ Checking the accuracy of categories of medication variance assigned by the nursing staff.	

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		The Pharmacy Department submitted a document entitled "Monitoring Instructions for Spot Check Audits," dated July 2013. This listed the nine steps the Pharmacy used in completion of the monthly audit process in the residences for this audit of Subsection N.8. Steps included: selecting a 20 percent sample from the current roster of individuals in each residence, printing the fill sheet for the residence and the selected individuals' medication lists, counting the number of medications remaining (i.e., tablets, controlled substances, and liquids) remaining in the medication room, justifying any discrepancies with information recorded in the MAR, sending audit results to the Unit Manger of the residence for action steps to be taken and action information communicated back to the pharmacy, review of audit information by the Medical Director, and return of audit information to the Pharmacy for compilation in a subsequent report. The Pharmacy also submitted copies of email communications to Nursing, which indicated that topical treatments were not being administered. For one individual, a topical gel had been pulled by Pharmacy as outdated in April 2013, as it had been filled in March 2012, and should have lasted no more than 90 days. Another topical treatment was pulled as it was nearing the date of expiration. It had been filled in October 2012 and should have lasted only 45 days. These findings indicated the medication variance rate was greater than in the reports, but appeared to not be captured in data, because the medication variance reports generally focused on tablets/liquids taken orally, or per feeding-tube. <u>Medication Error Reports</u> Copies of the last 10 medication error forms were submitted for review. The date of variance discovery ranged from 3/20/13 through 4/15/13. There were seven Class A medication errors, one Class B medication error, one Class C medication error, and zero Class D medication errors. Follow-up of the errors was documented on a form entitled "LBSS Staff Follow-up." This form included a brief description of the incident in 10 of 10 (100%) and a guidance step to prevent recurrence in 10 of 10 (100%). Nine of the medication variances were from the nursing staff, and one medication variance was due to Medical Department staff. <u>Medication Observation Monitoring</u> Based on observations that Facility staff conducted: ▪ For October 2012, ten observations were completed. There were two observations of RNs and eight observations of LVNs. The score range was 94 to 100 percent. There were three nurses that scored 100 percent. ▪ For November 2012, 14 observations were completed. The score range was 98 to 100 percent. There were two observations of RNs and 14 observations of LVNs. For 10 observations, the score was 100 percent.	

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		▪ For December 2012, 10 observations were completed. The score range was 97 to 100 percent. There were five observations of RNs and five observations of LVNs. For eight observations, the score was 100 percent. ▪ For January 2013, 12 observations were completed. The score range was 96 to 100 percent. There were five observations of RNs and seven observations of LVNs. For nine observations, the score was 100 percent. ▪ For February 2013, seven observations were completed. The score range was 96 to 100 percent. There was one observation of an RN and six observations of LVNs. For three observations, the score was 100 percent. ▪ For March 2013, 18 observations were completed. The score range was 94 to 100 percent. There were two observations of an RN and 16 observations of LVNs. For 14 observations, the score was 100 percent. ▪ For April 2013, 18 observations were completed. The score range was 91 to 100 percent. There were seven observations of RNs, and 11 observations of LVNs. For five observations, the score was 100 percent. ▪ For May 2013, 22 observations were completed. The score range was 92 to 100 percent. There were three observations of RNs, and 19 observations of LVNs. For 16 observations, the score was 100 percent. These medication observations are discussed in further detail with regard to Section M.6. However, given the large numbers of unexplained returned medications, and identification of medication variances that were not being reported, the validity of the results is questionable. As noted in the last report, the Pharmacy Department had worked with other departments to identify and put potential remedies in place to address medication variances. In addition to taking steps to ensure all medication variances were reported (e.g., those involving non-pill forms of medications), a significant remaining concern was the large number of unexplained returned medications. That it continued to occur on all three units indicates a need for further review in creating a system's approach to resolution. Of serious concern are the potential clinical implications of individuals possibly not receiving prescribed medication. It was not clear that the MSSC or other committee was cross referencing other data (e.g., seizure data, bowel movement records, etc.) to determine if there was any correlation between the medications being returned, and individuals experiencing poor outcomes. 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.	

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 The following documents for 15 individuals in Sample O.1 (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, Individual #125, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100), including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team (IDT) members to attend the annual ISP meeting, ISP Preparation Meeting documentation, Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual ISP and ISP Addendums for past year, Integrated Risk Action form, IDT Risk Action Plan/Integrated Health Care Plan, Integrated Progress Notes (IPNs) 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, 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 (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 four individuals in Sample O.2 (i.e., Individual #147, Individual #283, Individual #242, and Individual #78) on the PNMT caseload who were assessed or reviewed in the last six months. In addition, a sample of three individuals who had been discharged by the PNMT (Individual #226, Individual #6, and Individual #196), including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members to attend the annual ISP meeting, ISP Preparation Meeting documentation, PNMT assessment, PNMT action plan and supporting documentation, HOBE assessment, APEN assessment/tool, 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 The following documents for ten individuals in Sample O.3 (i.e., Individual #181, Individual #317, Individual #199, Individual #281, Individual #100, Individual #161, Individual #269, Individual #324, Individual #21, and Individual #128) including: OT/PT comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, APEN assessment/tool, SLP comprehensive assessment, SLP assessment of status, SLP update, HOBE assessment, annual ISP and ISAs for past year, Integrated Risk Action form, IDT 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, 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, documentation of staff successfully completing 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 Dining plans for the following 21 individuals: Individual #86, Individual #20, Individual #164, Individual #146, Individual #58, Individual #209, Individual #192, Individual #308, Individual #203, Individual #223, Individual #160, Individual #103, Individual #26, Individual #178, Individual #184, Individual #267, Individual #45, Individual #95, Individual #202, Individual #254, and Individual #7; o PNMPs for the following 28 individuals: Individual #304, Individual #175, Individual #74, Individual #167, Individual #17, Individual #191, Individual #312, Individual #37, Individual #176, Individual #298, Individual #172, Individual #250, Individual #160, Individual #12, Individual #76, Individual #192, Individual #308, Individual #77, Individual #282, Individual #275, Individual #209, Individual #280, Individual #199, Individual #90, Individual #185, Individual #62, Individual #258, and Individual #217; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged;

	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 needs; o Wheelchair/Mobility/Assistive Equipment Work Orders; o Completed PNMPs and Dining Plans; o List of tools that 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 competency 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 percent or greater over a six-month 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 the 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 residence; o Schedule of all PNM-related meetings occurring during the week of the Monitoring Team's 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 Assessments/Evaluations; o Quality Assurance/Quality Improvement (QA/QI) 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 the Monitoring Team's last review; o Changes to PNMP templates since the Monitoring Team's last review; o QA/QI Quarterly Section Review for Section O; o Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in NEO 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 At Risk Rating List; o License numbers of PNMT core members; o Copy of PNMT referral form; o List of approved trainers for NEO and annual refresher PNM foundational training; o List of approved trainers for PNM individual-specific training (i.e., non-foundational); o PNMPs for 32 individuals; o PNMT reports to Medical Morning meeting for the past three months; o List of PNM monitors, and for each monitor listed, include date of NEO training competencies completed, check-offs completed for validation and inter-rater agreement; o PNMT meeting minutes and attendance sheets complete after submission of pre-document request; o NEO training curriculum for PNM foundational training; o Copy of consultation report for referral to PNMT and response of PNMT for Individual #317, Individual #8, Individual #9, and Individual #68; o Updated list of individuals who are enterally nourished since the submission of the pre-document request; o Revised State PNMT assessment template; o Facility Guidelines for the development of a PNMP; o QA/QI Indicators for Sections O, P and R; o PNMT meeting conducted after the submission of the pre-document request; o HOB priority list, criteria for placement on list and date of HOBE assessments of individuals completed to date; o Facility Pulled Staff Procedures; o Procedures for Suction Oral Care; o Documentation of inter-rater agreement for Program Compliance Monitor (PCM) for Section O, P and R;

	○ Work orders for June 2012 including start and end date; and ○ Continuing education documentation for contract SLPs, OTs and PTs for the last year. ▪ **Interviews with:** ○ Linda Thomas, Director of Habilitation Therapy; ○ Denise Juarez, PNMT OT; ○ Jon Olive, PNMT PT; ○ Corey Verrett, PNMT RD; ○ Mitzi Umstot, PNMT SLP; ○ Heidi Hendrickson, PNMT RN; ○ Stephanie Hernandez, PNMT OT Back-up; ○ Kristen Walden, PNMT RD Back-up; ○ Stacie Duda, PNMT SLP Back-up; and ○ Diane Johnson, PNMT SLP Back-up. ▪ **Observations of:** ○ Individuals in multiple residences, dining rooms, and day programs; and ○ PNMT meeting on 7/11/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 6/20/13. 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 O, in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, as well as interviews with the Director of HT, the following was found: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring tool, audits, and databases. The HT Department was not using the Settlement Agreement Monitoring Tool for Section O. ○ The Compliance Monitoring tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. However, the data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking attendance at PNMT meetings for PNMT and IDT members, the PNMP audit tool, etc. The data presented represented a positive move forward in monitoring compliance with Section O. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. ○ The monitoring tool included adequate methodologies, such as observations, record review, and staff interview. ○ The Self-Assessment identified the sample sizes, and how the sample was chosen. ○ The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tool: The Director of HT, therapists, and a PCM.

	○ Adequate inter-rater reliability had not been established between these monitors. ▪ The Facility used some other relevant data sources, including, for example, PNMT meeting sign-in rosters, continuing education database, and the PNMP database/spreadsheet, etc. ▪ The Facility presented some of the data in a meaningful/useful way, but in other instances work was needed. Specifically, the Facility's Self-Assessment: ○ Did not present findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Section O.1 and O.5. The Monitoring Team did not find the Facility in substantial compliance with Section O.1 and O.5. However, the Facility had made significant progress within these sections. The Facility rated itself in noncompliance with the remaining sub-sections (i.e., O.2, O.3, O.4, O.6, O.7, and O.8). These findings were 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 referencing 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's PNMT had the required core members as outlined in the Settlement Agreement, and was meeting regularly. However, a review of PNMT documentation did not support routine participation by medical providers. The Facility PNMT policy had been revised, but necessary components were missing to define the monitoring process. The PNMT had made significant progress in the production of comprehensive PNMT assessments. Since the Monitoring Team's last review, progress had been made with individuals' PNMPs having more of the necessary components. The Facility had developed and implemented a PNMP audit tool. The Monitoring Team, members of the PNMT, Facility therapists, leadership staff of the Mealtime Coordinator Committee (i.e., Active Treatment Coordinator and Safety Officer) completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk. The Facility had made substantial progress in the provision of PNM foundational training for new employees and veteran staff. Additional work was needed to ensure staff providing supports to individuals received individual-specific training. The Facility had not implemented an effectiveness monitoring system to assess individuals' progress in relation to their physical and nutritional management needs, or provide evidence that interventions were

	modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' 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 maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have formal plans.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan 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	As noted above with regard to the documents reviewed section, four samples were selected for the review of Section O. These included: ▪ **Sample O.1** consisted of a non-random sample of 15 individuals chosen from a list the Facility provided of individuals identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, or osteoporosis], requiring mealtime assistance and/or prescribed a dining plan, at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room, and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These 15 individuals were: Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, Individual #125, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100. ▪ **Sample O.2** consisted of 100 percent of the individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included four individuals: Individual #147, Individual #283, Individual #242, and Individual #78. In addition, a sample of three individuals who had been discharged by the PNMT was selected, including: Individual #226, Individual #6, and Individual #196. This did not include any duplication from Sample O.1. ▪ **Sample O.3** consisted of 10 individuals who received enteral nutrition. These 10 individuals were: Individual #181, Individual #317, Individual #199, Individual #281, Individual #100, Individual #161, Individual #269, Individual #324, Individual #21, and Individual #128. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 49 individuals (i.e., Individual #86, Individual #20, Individual #164, Individual #146, Individual #58, Individual #209, Individual	Noncompliance

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	management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	#192, Individual #308, Individual #203, Individual #223, Individual #160, Individual #103, Individual #26, Individual #178, Individual #184, Individual #267, Individual #45, Individual #95, Individual #202, Individual #254, Individual #7, Individual #304, Individual #175, Individual #74, Individual #167, Individual #17, Individual #191, Individual #312, Individual #37, Individual #176, Individual #298, Individual #172, Individual #250, Individual #160, Individual #12, Individual #76, Individual #192, Individual #308, Individual #77, Individual #282, Individual #275, Individual #209, Individual #280, Individual #199, Individual #90, Individual #185, Individual #62, Individual #258, and Individual #217) observed in the residences, dining rooms and day programs. This included random, individual-specific observations as well as observations of individuals in Sample O.1 and O.2. 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. **PNM Policy and Role of the PNMT** The Facility submitted the following policies: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ LBSSLC – IDT Process – Program Development Physical Nutritional Management, revised 3/20/13; ▪ LBSSLC PNMT Guidelines, dated 3/4/13; and ▪ LBSSLC – Review Processes Quality Assurance Process/Plan, revised 8/30/12; The Facility's policy, including the State PNM policy, was not a comprehensive PNM policy that included the following elements: (note: This addresses the presence of a State/Facility PNM policy. The implementation of these elements is addressed with regard to Sections O.2 through O.8.) Although the policies included many of the	

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		necessary components, those that were missing included the following: ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide); o Identification of monitors and their roles and responsibilities; o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring; o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician; and o Frequency of monitoring to be provided to individuals at all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as HT and the PNMT is collected, trended, and analyzed; o Process for the HT and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Provider Morning meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and	

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		implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. **Core PNMT Membership** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, and a Speech Language Pathologist. **Consultation with Medical Providers and IDT Members** A review of the Facility PNM policy Section H identified the following statement in Other Participants of PNMT: "upon request of the PNMT, the PNMT may include the primary care provider, case load therapists, nurse case manager, psychologist, Qualified Developmental Disabilities Professional (QDDP), dental staff, pharmacist, support services staff or others as needed." A medical liaison had not been assigned to the PNMT. For none of the four (0%) individuals in Sample O.2, evidence was provided of routine participation of medical providers in meetings, review of assessments, and other needed activities. The PNMT should always consult with the individual's medical provider during the completion of the PNMT assessment and ongoing follow-up, because they provide supports to high-risk individuals with significant health, physical, and nutritional concerns. Medical providers (primary care physician) were present in 12 of 42 (29%) PNMT meetings. For four of the four (100%) individuals in Sample O.2, evidence was provided of routine participation of other IDT members (i.e., QDDP, RN Case Manager, and Residential Coordinator) in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Five of five (100%) PNMT members were licensed to practice in the state of Texas. Five of five (100%) PNMT core members had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Specialized training is defined as graduate education or continuing education content that is relevant to enhancing the provision of supports to individuals with identified PNM concerns. **Continuing Education** Four of five (80%) PNMT staff had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. The PNNT SLP was assigned to the PNMT on 3/1/13	

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		and had completed six hours of continuing education to date. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Texas Ethics and Professional Responsibility (7/23/12), Anatomy of Swallowing (8/1/12), Hard to Swallow: Management of Dysphasia in Older Persons (10/25/12), Equipment Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI issues in Individuals with Developmental Disabilities (3/6/13), Advances in Motor Control and Learning for Neurological Rehab (5/29/13), and Anatomy of Swallowing (no date) for a total of 12.6 hours; ▪ SLP, assigned to PNMT on 3/1/13, attended: Equipment Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issues in Individual with Developmental Disabilities (3/6/13), and Least Restrictive Method of Feeding (4/3/12) for a total of six hours; ▪ OT, assigned to PNMT on 11/1/12, attended: Standard Precautions (7/13/12), Risk Training (7/13/12 and 7/24/12 to 7/26/12), Fight the Bite (8/17/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Temple Grandin: Autism and My Sensory Based World (12/5/12), Autism and Sensory Processing Disorders (2/7/13), Dysphagia/GI Issues in Individuals with Developmental Disabilities (2/13/13), Equipment Webinar (3/6/12), The Evaluation and Treatment of Dysphagia (10/19/12), Care of the Patient with Ostomy (2/13/13), Equipment Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issues in Individual with Developmental Disabilities (3/6/13), and Least Restrictive Method of Feeding (4/3/12) for a total of 26.5 hours; ▪ RD attended: Dysphagia: A Growing Concern in Healthcare (7/25/12), Advance Enteral Solutions/Spike Sets (8/29/12), The Evaluation and Treatment of Dysphagia (10/19/12), Hard to Swallow: Management of Dysphagia in Older Persons (10/25/12), Pressure Ulcer Management: Nutrition Guidelines for Your Challenging Patients (1/23/13), Equipment Webinar (2/7/13), Care of the Patient with Ostomy (2/13/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issues in Individual with Developmental Disabilities (3/6/13), and Least Restrictive Method of Feeding (4/3/12) for a total of 18.5 hours; ▪ RN attended: Austin Risk Training/ISP Process/IHCP Training (9/11/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Medication Administration for Nurses (10/4/12), Issues in Evaluation and Treatment of Individuals with Developmental Disabilities Part 1 (10/4/12), Issues in Evaluation and Treatment of Individuals with Developmental Disabilities Part 2 (10/4/12), From Intensive Care to Long Term Care: Nutritional Management of Pressure Ulcers (10/26/12), Non Healing Wounds and Biofilm (12/6/12), Critical Issues to Reduce Osteoporosis Fracture Risk in Vulnerable Individuals	

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		(12/21/12), Pressure Ulcer Management: Nutritional Guidelines for the Challenging Patient (1/23/12), RSV (Respiratory Syncytial Virus) Bronchiolitis: Prevention, Identification, and Management (2/7/12), Equipment Webinar (2/7/12), and Care of the Patient with Ostomy (2/13/12) for a total of 51.25 hours; and ▪ Physical Therapy Assistant (PTA) attended: Risk Training (7/24/12 to 7/26/12), Annual Habilitation Therapies Conference (9/20/12 to 9/21/12), Medication Administration for Nurses (10/4/12), Hard to Swallow: Management of Dysphagia in Older Persons (10/25/12), Temple Grandin: Autism and My Sensory Based World (12/5/12), Autism and Sensory Processing Disorders (2/7/13), Equipment Webinar (2/7/12), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issues in Individual with Developmental Disabilities (3/6/13), Least Restrictive Method of Feeding (4/3/12), and Advances in Motor Control and Learning for Neurological Rehab (5/29/13) for a total of 33 hours. **PNMT Meetings** From January 3, 2013 to July 3, 2013, the PNMT met 42 times. The team met 24 of the 26 (92%) weeks, and often met more than once a week. There were five back-up members (i.e., RD, OT, PT, RN, and SLP). Attendance by core PNMT and back-up members for 42 meetings conducted during the time frame from January 3, 2013 to July 3, 2013 was: ▪ RN: 67 percent attendance by core member, nine percent for back-up member, and 76 percent overall; ▪ RD: 78 percent attendance by core member, 14 percent for back-up member and 92 percent overall; ▪ PT: 64 percent attendance by core member, 28 percent for back-up member, and 92 percent overall; ▪ OT: 28 percent attendance by core member, 71 percent for back-up member, and 99 percent overall; and ▪ SLP: 67 percent attendance by core member, 11 percent for back-up member, and 78 percent overall. Forty-two of the 42 (100%) PNMT meeting minutes (January 2013 to July 2013) included documentation of appropriate topics, including at a minimum: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMT did have a system implemented for resolution of systemic	

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		issues/concerns. The Director of HT identified three pathways for the PNMT to resolve systemic concerns which might negatively impact outcomes for individuals with PNM concerns, including: daily Incident Management Review Team Meetings, daily Provider Morning meetings, and QA/QI Council meetings. In addition, a PNMT member provided a weekly update during the Provider Morning meeting. The PNMT RN maintained a PNM episodes list (tracker) for all individuals at the Facility to monitor for trends. The following individual-specific episodes were tracked: ▪ Decubitis; ▪ Fractures of long bones; ▪ Choking incidents; ▪ Pneumonia; ▪ Emesis; ▪ Weight loss (5 percent in one month, 7.5 percent in three months, or 10 percent in six months); and ▪ Hospitalizations for respiratory compromise, gastrointestinal issues, bowel obstruction, dehydration, and any other episode that might impact an individual's PNM status. It was the responsibility of the PNMT RN to review the episode list daily to determine if an individual should be referred to PNMT and/or to alert the individual's IDT to ensure a plan was in place and/or to address the issues. Based on interview with the Director of HT, there were plans to transition the Episode Tracker to be maintained by and discussed during the Provider Morning meeting. In summary, the Facility had made progress within this section. At the time of the Monitoring Team's review, the Facility's PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. The PNMT members were qualified, and had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. However, additional work needed to be done. Medical consultation with the PNMT on a consistent basis was not evident. The Facility's PNM policy should address the necessary components presented within this section. The Facility remained out of compliance with this provision.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires	**Identification of PNM Risk** The Facility did have lists which identified individuals who require mealtime assistance, who require positioning assistance associated with swallowing activities, who have difficulty swallowing, or who are at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). However, the Facility did not have policies and/or procedures to define their process for implementing	Noncompliance

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	positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	a sustainable system to maintain and update lists of individuals who required mealtime assistance, positioning assistance associated with swallowing activities, who have difficulty swallowing, and individuals who required assistance to eat. A sustainable system is needed to maintain and update these lists to ensure 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. Based on documentation provided, PNMPs were developed and implemented for 168 of the 211 individuals at LBSSLC. However, two individuals in Sample O.1 did not have PNMPs (i.e., Individual #125 and Individual #20). These individuals had experienced multiple falls. The following concerns were noted: ▪ The document "Falls 11/15/12 to 5/15/13" (i.e., TX-LB-1307-XII.15p) noted Individual #125 experienced seven falls during this time period: 11/19/12, 12/3/12, 1/3/13 (transported to emergency room), 1/7/13 (transported to emergency room), 2/5/13, 3/29/13, and 5/13/13. However, a review of the records identified additional falls: ISPA noted a fall on 3/30/13 which required a transport to the emergency room where he received 17 staples to the injury; and IPN, dated 5/13/13, noted an additional fall. His IRRF, dated 8/13/12, ranked him at high risk for falls with the following justification: "due to history of falls alone warranted this high classification…" However, no information was provided for the reason for the number of falls and the team had not updated his IRRF to reflect subsequent falls. A PT follow-up to an ISPA for helmet use consideration, dated 4/10/13, noted the following recommendations: consider tracking falls, tracking of medication changes, use of a bed sensor at night to offer assistance when he gets up to use the restroom, use of a helmet during waking hours, use of more invasive assistance when walking, and use of a wheelchair for all mobility until a cause of his falls can be determined. It was unclear why Individual #125's therapist did not recommend the development and implementation of a PNMP to provide staff with strategies to minimize his risk of falling. ▪ The document "Falls 11/15/12 to 5/15/13" (i.e., TX-LB-1307-XII.15p) noted Individual #20 had fallen seven times: 11/15/12, 11/22/12, 11/26/12, 12/12/12, 1/17/13, 1/25/13, and 3/21/13. A HT consultation for a gait evaluation following falls, dated 10/31/12, recommended: "staff should continue to stand nearby [Individual #20] during weight bearing activities (standing, transferring and ambulating) so that she may reach out to hold [on] to them if she fells dizzy/off balance. Having staff stand on [Individual #20's] left side and offer verbal cueing may decrease her drift to the left as she ambulates." It was unclear why her physical therapist did not develop and implement a	

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		PNMP to provide staff with these strategies to minimize her risk of falling. **Physical and Nutritional Management Team Referral Process** Individuals in Sample O.1 were reviewed to determine if they met the State and Facility PNM policy criteria for referral to the PNMT. The review found that one individual (i.e., Individual #58), who should have been referred, was not appropriately referred to the PNMT based on the criteria included in the policies. More specifically: ▪ Ten individuals (i.e., Individual #20, Individual #66, Individual #125, Individual #324, Individual #171, Individual #21, Individual #199, Individual #308, Individual #181, and Individual #100) did not meet the referral criteria. ▪ Four individuals (i.e., Individual #161, Individual #269, Individual #281, and Individual #317) were referred and/or reviewed by the PNMT based on the referral criteria. ▪ One of the 15 individuals met the referral criteria and should have been referred to the PNMT, but was not: o Individual #58 experienced a choking incident on 5/5/13. He was not referred to the PNMT for a consultation. For four of four (100%) individuals referred to the PNMT as noted above, a referral had been made within five working days of an ISP and/or ISPA meeting. Two of two (100%) individuals (i.e., Individual #317 and Individual #147) who received an emergency feeding tube placement since the last Monitoring Team review had been referred to the PNMT after the emergency feeding tube placement. Based on Facility report, no individual had received a non-emergency feeding tube placement since the last review. In future reviews, if any were, the following metric would be assessed: ____ of ____ individuals (%) who received a feeding tube (not on an emergency basis) since the last review (%) had been referred to the PNMT prior to the placement of the tube. **PNMT Assessment** For the individuals in Sample O.2, four of four (100%) PNMT assessments (i.e., Individual #147, Individual #283, Individual #242, and Individual #78) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). None of four (0%) PNMT assessments were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (i.e., critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). These timeframes should be followed, but actions that are identified earlier	

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		or require more expedient implementation should be implemented as they are identified. Based on review of individuals' records, the comprehensiveness of the PNMT assessment components were as follows: ▪ Four of four (100%) contained date of referral by the IDT; ▪ Four of four (100%) contained the date the assessment was initiated; ▪ Four of four (100%) contained evidence of review and analysis of the individual's medical history; ▪ Four of four (100%) identified the individuals' current risk rating(s), including the current rationale; ▪ Four of four (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Four of four (100%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Four of four (100%) (i.e., Individual #147, Individual #283, and Individual #78) contained assessment of current physical status; ▪ Three of four (75%) (i.e., Individual #147, Individual #283, and Individual #78) contained assessment of musculoskeletal status; ▪ Three of four (75%) (i.e., Individual #147, Individual #283, and Individual #78) contained evaluation of motor skills; ▪ Three of four (75%) (i.e., Individual #147, Individual #283, and Individual #78) contained evaluation of skin integrity. The PNMT assessment should have indicated that skin integrity was not an issue for Individual #242; ▪ Four of four (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Four of four (100%) contained evaluation of current adaptive equipment. ▪ Four of four (100%) contained nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ None of four (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ Four of four (100%) identified residual thresholds, if enterally nourished; ▪ One of one (100%) (i.e., Individual #147) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. Individual #283, Individual #242, and Individual #78 were receiving enteral nutrition at the time of their referral to the PNMT and as a result, a tableside oral motor/swallowing assessment would not be applicable; ▪ Four of four (100%) contained respiratory status; ▪ Four of four (100%) contained evidence of review/analysis of lab work; ▪ None of four (0%) contained evidence of review/analysis of medication history	

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		over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Four of four (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ Three of four (75%) (i.e., Individual #147, Individual #283, and Individual #78) contained oral hygiene status; ▪ Four of four (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Four of four (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Four of four (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Four of four (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ Two of two (100%) (i.e., Individual #147 and Individual #78) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ Four of four (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ Four of four (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Four of four (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); ▪ Four of four (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ Four of the four (100%) contained signatures with dates. The PNMT had made substantial progress in providing comprehensive PNMT assessments. They contained the majority of components necessary. This was encouraging, and with a few modifications, the PNMT assessments should include all necessary components. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For none of the four (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs and IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In four of the four (100%) individuals' plans reviewed, the plans addressed the	

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		individual's identified PNM needs as presented in the PNMT assessment. ▪ For two of the two (100%) (i.e., Individual #283 and Individual #78) individuals for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. ▪ In none of the four (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In four of the four (100%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In four of the four (100%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In four of the four (100%) individuals' plans reviewed, the plans defined triggers. ▪ In four of the four (100%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of four (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. The Monitoring Team was not able to discern if the PNMT action plans had been implemented within 14 days. ▪ In four of the four (100%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. **Individuals Discharged by the PNMT** Review of three individuals' discharge summaries (i.e., Individual #226, Individual #6, and Individual #196,) developed by the PNMT and ISPAs found: ▪ Based on review of ISPAs, one of the three (33%) (i.e., Individual #196) individuals had a meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ Three of the three (100%) individuals' discharge summary/action plans provided objective clinical data to justify the discharge. ▪ One of the three (33%) (i.e., Individual #196) individual's ISPA meeting documentation provided evidence that any new recommendations, as	

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		appropriate, were integrated into the IHCP. ▪ Three of the three (100%) individuals' discharge summaries included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the PNMT had made significant progress within this section by producing an assessment and action plans that included the majority of the necessary components. Individuals meeting PNMT referral criteria were being referred. However, PNMT action steps were not fully integrated into individuals' risk action plans and/or IHCPs. Individuals' discharge plans were not integrated into the ISP and/or ISPA. The Facility remained out of compliance with this provision.	
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.	**Identification of Individuals Requiring a PNMP** None of the 13 (0%) individuals' annual ISPs in Sample O.1 noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. Individuals' annual ISP meetings lacked attendance by appropriate disciplines and/or there was not adequate justification in the ISP Preparation Meeting documentation to support non-attendance of therapists and/or dieticians. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, residential staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current 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 individuals' care and treatment do not need to attend. In assessing this requirement, the Monitoring Team reviewed the ISP Preparation Meeting documentation that should have included such information, as well as the ISP sign-in sheets. None of 13 (0%) PNMPs in Sample O.1 were reviewed by the individual's IDT in the annual ISP meeting. Individuals' ISPs would state the PNMP was reviewed, but there was no evidence that the teams addressed the effectiveness of the PNMP and/or discussed any updates and/or revisions to an individual's PNMP. This needed to include evidence of review, update/revision, effectiveness, and specified changes required with rationale. **PNMP Format and Content** A review of 13 PNMPs (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100) and two dining plans (Individual #125 and Individual #20) in Sample O.1 (15 individuals) found the following: ▪ PNMPs for 13 of 13 (100%) individuals were current within the last 12 months. ▪ PNMPs for 11 of 13 (85%) (i.e., Individual #181, Individual #281, Individual	Noncompliance

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		#161, Individual #308, Individual #269, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100) individuals included a list of all high-risk levels, individual triggers, and outcomes. ▪ In 13 of 13 (100%) most current PNMPs, there were large and clear photographs with instructions. ▪ Thirteen of 13 (100%) PNMPs listed the adaptive equipment required by the individual with rationale. ▪ In seven of 11 (64%) (i.e., Individual #308, Individual #269, Individual #171, Individual #281, Individual #66, Individual #161, and Individual #199) PNMPs for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided. The PNMPs reviewed for the remaining individuals who used wheelchairs as their primary mobility did not include written and/or pictorial instructions for staff to achieve safe elevation ranges, and/or the frequency of re-positioning. PNMPs for Individual #181, Individual #317, and Individual #58 did not include the frequency of wheelchair positioning. The wheelchair written and pictorial instructions for Individual #324 did not provide the safe degree of elevation. Individual #20 and Individual #125 were not assigned wheelchairs and used home loaner wheelchairs for medical appointments. ▪ In 13 of 13 (100%) PNMPs, positioning was adequately described per the individuals' assessments. A review of OT/PT assessments showed they provided a description of alternate positioning, which should include safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 13 of 13 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. • In nine of 13 (69%) PNMPs (i.e., Individual #269, Individual #181, Individual #281, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100), bathing instructions were provided. For these individuals, instructions included bathing equipment, strategies, independence, and level of staff assistance required. Further clarification is provided below: o Individual #317's bathing instructions did not include staff strategies, level of independence, and/or level of staff assistance required. o Individual #66's bathing instructions had written and pictorial instructions for a shower chair, dated 6/5/13, but her PNMP, revised 1/18/13, indicated an Arjo tub and/or bathing trolley was to be used. In addition, the bathing instructions did not include staff strategies, level of independence, and/or level of staff assistance required. o Individual #308's bathing instructions stated: "use Arjo tub." The	

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		bathing instructions did not include safe degree of elevation. o Individual #269's bathing instructions indicated: "Arjo tub with head of lift elevated and check residuals prior to bathing." These instructions did not include the safe degree of elevation for the head of the lift. o Individual #100's bathing instructions did not include staff strategies, level of independence, and/or level of staff assistance required. ▪ In three of 13 (23%) PNMPs, (i.e., Individual #181, Individual #281, and Individual #161), toileting-related instructions were provided, including check and change. For the remaining 10 individuals, there were no instructions provided to identify the level of independence, degree of safe elevation, and/or level of staff assistance required during toileting. ▪ In 13 of 13 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 15 of 15 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Fifteen of 15 (100%) dining plans were current within the last 12 months. ▪ Nine of 13 individuals had feeding tubes with no oral intake (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #269, Individual #324, Individual #21, and Individual #199). One of nine (11%) (i.e., Individual #324) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 11 of 15 (73%) PNMPs/dining plans (i.e., Individual #181, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, Individual #324, Individual #58, Individual #171, Individual #21, and Individual #199), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Six individuals ate orally within this sample (i.e., Individual #20, Individual #308, Individual #125, Individual #58, Individual #171, and Individual #100). o In six of six (100%) PNMPs/dining plans for individuals who ate orally diet orders for food texture were included. o In six of six (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In one of six (17%) (i.e., Individual #125) PNMPs/dining plans for individuals who ate orally, dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. The remaining five individuals' dining plans listed adaptive equipment, but no rationale was provided. ▪ In six of 13 (46%) (i.e., Individual #181, Individual #66, Individual #269, Individual #324, Individual #21, and Individual #199) PNMPs, medication	

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		administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In six of 13 (46%) (i.e., Individual #66, Individual #161, Individual #269, Individual #324, Individual #21, and Individual #199) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. ▪ Thirteen of 13 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 13 individuals in Sample O.1 with PNMPs for whom the IDT and/or PNMT identified changes needed to be made to the PNMP, 10 of 13 (77%) (i.e., Individual #181, Individual #66, Individual #161, Individual #269, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100) individuals had ISPA meetings for PNMP revisions that required a meeting to approve revisions based on the individual's change in status and/or email documentation to relevant IDT members that noted the PNMP had been revised. For individuals for whom the PNMP was revised, there was supporting documentation that 10 of the 13 (77%) individuals' revised PNMPs had been implemented. Progress had been made since the last review with individuals' PNMPs having more of the necessary components. However, PNMPs were missing components. The Facility had developed and implemented a PNMP audit tool. The Facility remained out of compliance with this provision.	
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** Staff did not engage in safe mealtime practices for individuals who ate orally and/or received enteral nutrition. Based on the Monitoring Team's observations, none of the 21 (0%) individuals (i.e., Individual #86, Individual #20, Individual #164, Individual #146, Individual #58, Individual #209, Individual #192, Individual #308, Individual #203, Individual #223, Individual #160, Individual #103, Individual #26, Individual #178, Individual #184, Individual #267, Individual #45, Individual #95, Individual #202, Individual #254, and Individual #7) dining plans were implemented as written. Based on observations: ▪ None of eight (0%) individuals were positioned correctly in their seating systems (i.e., Individual #304, Individual #283, Individual #298, Individual #172, Individual #185, Individual #250, Individual #199, and Individual #90); ▪ Eight of 24 (33%) individuals' alternate positioning plans (i.e., Individual #312,	Noncompliance

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		Individual #37, Individual #78, Individual #176, Individual #161, Individual #12, Individual #282, and Individual #209) were implemented as written. Staff were not following PNMP strategies for alternate positioning for the following 16 individuals: Individual #175, Individual #74, Individual #269, Individual #226, Individual #167, Individual #17, Individual #191, Individual #6, Individual #324, Individual #317, Individual #160, Individual #192, Individual #76, Individual #308, Individual #275, and Individual #77; ▪ One of two (50%) mechanical lift transfers (i.e., Individual #280) performed by staff were completed correctly; ▪ In none of three (0%) observations of medication administration passes (i.e., Individual #191, Individual #217, and Individual #258), the nurse followed procedures in the PNMP. The PNMP provides the foundation for health and safety. These observations completed by the Monitoring Team showed that staff were not competent and/or compliant in implementing foundational PNMP and dining plan strategies. This was concerning in that the staff's failure to implement PNMPs was an issue during the Monitoring Team's last onsite review, and, unfortunately, continued to be of concern during this review. The Facility should move forward to provide additional support to staff to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk. As discussed with regard to Section O.5, the Facility continued to revise and improve a mealtime accountability system to support staff compliance with dining plans. In summary, the Facility should place a high priority on staff compliance with individuals' PNMPs. The Facility remained out of compliance with this provision.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**<u>New Employee Orientation (NEO) Orientation</u>** NEO orientation should contain the following elements: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. The HT Department revised the following PNM foundational training curriculums: ▪ "PNMP, Assistive Equipment and Wheelchairs" PowerPoint presentation which incorporated the new PNMP format, revised contents of the PNMP, and Blue PNMPs for individuals supported by the PNMT (April 2013); ▪ Braces and Positioning (October 2012); ▪ Mealtime Assistance (May 2013);	Noncompliance

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		▪ Feeding and Mealtime Management (May 2013); ▪ Lifting (April 2013); and ▪ Communication (March 2013). The following categories of LBSSLC staff required PNM-related NEO training: ▪ All direct support staff which includes all residential, programs, vocational, recreational and active treatment; and ▪ Professional direct staff, including psychology, QDDPs, and nursing. The Facility had developed and implemented a PNM foundational competency-based training curriculum, which contained the necessary components as described above and was considered comprehensive. The Facility reported that 97 of 97 (100%) staff members had successfully completed PNM NEO foundational training and competency check-offs during the previous six months. **PNM Core Competencies for Current Staff** A curriculum for PNM foundational competency-based training curriculum was implemented in April 2013 for veteran staff. From April 8 through June 27, 2013, 95 percent of direct support professionals and professional staff had successfully completed the PNM foundational competency-based training and performance check-offs. The Facility provided lists of staff who had completed PNM foundational courses, however, these lists did not provide the total number of staff who had completed the PNM foundational courses. The following metric will be assessed during the next review: _____of _____ current staff that require training (%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. **Annual Refresher Training** Beginning September 1, 2013, the PNM foundational competency-based training curriculum will be taught twice a month. This training will be an annual mandatory training for direct support professionals and professional staff. However, at the time of the Monitoring Team review, campus-wide PNM foundational training had been completed for the majority (95%) of veteran staff (i.e., direct support professionals and professional staff). The following metric will be assessed during the next review: ▪ _____ of _____ current staff that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months.	

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		Individual Specific Training Staff should participate in an in-service to review PNMPs prior to their implementation. This should include all direct support professionals, including pulled/relief staff, responsible for specific individuals with physical or nutritional management problems, providing care that is affected by the PNMP. This review should consist of sharing information about the core competencies (i.e., foundational skills) included in the PNMP. If more individualized supports are needed, further training should be provided, as discussed below. Based on interview and review of documentation, the HT Department PNMP Coordinators provided individual-specific training, and after a period of seven working days turned over responsibility to the Residential Coordinator or Home Team Leader. Competency-based training documentation for these other staff reportedly was maintained. In addition, pulled staff were provided training on PNMPs when they were assigned to another residence. However, the training record documentation identified numerous veteran and pulled staff that had not received individual-specific training. Individual-specific training documentation for some of the individuals in Sample O.1 was reviewed. The Facility provided copies of individual-specific in-service staff signature sheets and Residential Service Direct Care Sign In/Out Sheets, which, for the most part, corresponded with the training dates. These documents were reviewed to determine if all staff, who were present during a specific time period, had received individual-specific training. More specifically: ▪ Individual #161's staff received individual-specific training on right sidelying in bed/day bed. The in-service sheet documented 22 staff had completed training during the time period of 4/26/13 through 5/3/13. Residential Services Direct Care Sign/In/Out Sheets were provided for the time period from 4/28/13 to 5/3/13. An additional eleven staff who were assigned to work with the individual had not received individual-specific training for Individual #161's right sidelying position in her bed and/or day bed. ▪ Individual #317's staff in Quail received individual-specific training on her dining plan during the time period of 6/12/13 to 6/20/13. However, the Residential Services Direct Care Sign/In/Out Sheets from 6/12/13 to 6/15/13 were from 525 North Cedar Avenue. The Monitoring Team was not able to analyze this data. ▪ Individual #171's staff received individual-specific training on his temporary PNMP during the time period of 4/15/13 to 4/23/13. The Residential Services Direct Care Sign In/Out Sheet during the time period of 4/19/13 through 4/23/13 identified an additional eight staff that had not received this individual-specific training. ▪ Individual #269's staff were provided individual-specific training on her dining	

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		plan on 11/12/12 through 11/19/12. However, the Residential Serviced Direct Care Sign In/Out Sheets provided were not in alignment with these dates. ▪ Twenty-six staff were provided individual-specific training on Individual #58's dining plan and PNMP during the time period of 11/13/12 through 11/19/12. The Residential Services Direct Care Sign In/Out Sheet identified an additional 11 staff that had not been trained. ▪ Nineteen staff were provided individual-specific training for Individual #329's PNMP during the time span of 2/11/13 to 2/15/13. The Residential Services Direct Care Sign In/Out Sheet for 2/15/13 only was provided. Two staff who worked on 2/15/13 had not received training. ▪ Twenty-seven staff were trained on Individual #308's PNMP during the time period of 5/10/13 through 5/22/13. Residential Services Direct Care Sign In/Out Sheets from 5/10 through 5/17/13 were submitted. Twelve additional staff worked during this time period, but had not received training. ▪ Blank competency-check off sheets were attached to some of the in-service sheets. However, for many individuals there was no example of the competency check-off form that staff had been responsible for completing. Consequently, it was difficult to discern what had been trained. In addition, the trainer had not indicated on the form that staff had successfully demonstrated the skills that were being trained. It was positive that the HT Department staff was providing individual-specific training. However, additional work was needed to develop a system to ensure all required staff, including pulled staff, received individual-specific training for the individuals they supported on a daily basis. In addition, the in-service from should clearly state the skills being tested. This training should be tracked in a Facility database. The Facility provided documentation for individual-specific training. However, the Monitoring Team was not able to assess the following metrics with the information provided. The following metrics will be assessed during the next review: ▪ For ___ of ____ staff assigned to individuals with PNMPs in Sample O.1 and O.2, (%) there is evidence of exchange of the information included in the PNMP prior to the provision of services. ▪ _____ of _____ staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. Therapy support staff (i.e., PNMP Coordinators) responsible for training other staff had completed competency-based training and performance check-offs for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training	

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		other staff on the PNMP/Dining Plan. At the time of the review, the approved trainers for individual-specific (i.e., non-foundational) training were one RN, four OTs, three PTs, four SLPs, three RDs, one PTA, and one trainer. There were no PNM competency performance check-offs submitted for the one trainer identified as a PNM individual-specific trainer. The Facility did not have a written procedure that defined the validation process that staff responsible for training other staff was competent to assess other staff's competency. **Facility Mealtime Coordination Committee Initiatives** The Monitoring Team met with members of the Mealtime Coordinator Committee (i.e., Assistant Director of Programs, Active Treatment Coordinator, Safety Officer and Occupational Therapist) and received an update on the Mealtime Coordinator Initiative, including the following: ▪ There were 101 active Mealtime Coordinators (MTC); ▪ 58 of 101 MTCs (57%) had successfully completed the MTC performance check-off; ▪ 75 of 101 (74%) MTCs have completed at least one competency check; ▪ An MTC training session would be conducted on a monthly basis to ensure there was an adequate number of MTCs; and ▪ Eight staff were performing the MTC competency check-offs (i.e., two Residential Coordinators, Safety Officer, Director of Vocational/Programs, QDDP Educator and two Campus Coordinators). Assistance was requested for the HT Department as needed. There were a number of new initiatives that had been implemented: ▪ A Table Captain competency-based training curriculum had been developed and implemented in NEO on April 1, 2013; ▪ MTC schedules had been implemented in every residence; ▪ Residential protocols had been developed and implemented in every residence. These protocols provided individual-specific and residence-specific information to MTCs and Table Captains for tasks that needed to be completed before, during, and after a meal; ▪ Staff badges acknowledged MTCs who had successfully completed competency check-offs; ▪ Video surveillance mealtime monitoring had been initiated. This process involved selecting a previous random date and reviewing three meals for every residence. The monitors would complete a report and forward to the ADOP for review. The ADOP reported that monitoring report results were shared with Residential Coordinators. Various actions had been taken to resolve areas of staff non-compliance with dining plans and Facility procedures, such as disciplinary action. The Facility administration provided commendation to	

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		Residential Coordinators and residential staff for exemplary mealtime monitoring results derived from the video surveillance; ▪ A significant push had been started to complete one competency check-off for all active MTCs; ▪ Plans were being developed to provide annual refresher training for all active MTCs. A refresher training had been developed and forwarded to the State Office to become an ILearn online training module; ▪ LBSSLC had provided coaching and mentoring to other State Supported Living Centers on the development and implementation of the Mealtime Coordination Initiative; ▪ An MTC database was in the process of being revised to enable the ADOP to run reports to retrieve the number of MTCs trained and the number of competency checks completed and/or not completed and mealtime monitoring results; and ▪ Meals were being monitored by Residential Coordinators. As stated with regard to Section O.4, the Monitoring Team had the opportunity to observe meals with the Active Treatment Coordinator and Safety Officer who were the MTC Committee leadership staff. The Monitoring Team, Active Treatment Coordinator, and Safety Officer were in agreement with mealtime observations in which staff were implementing dining plans correctly and/or incorrectly. Although in multiple residences, staff were not following dining plan strategies, these MTC members acknowledged problems with staff compliance, but had plans, as stated above, to build a system that supported individuals' safety during mealtimes. The Facility's interdisciplinary initiatives should support building a sustainable system for mealtime safety. The Facility had made significant progress in providing PNM foundational training. Veteran staff, which included direct support professionals and professional staff, had completed PNM foundational training. Beginning in September 2013, mandatory annual refresher training would be required for direct support professionals and professional staff. However, additional work needed to be done to ensure staff providing supports to individuals, successfully complete PNM individual-specific training. The Facility remained out of compliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately	**Facility's System for Monitoring of Staff Competency with PNMPs** The Compliance Monitoring tool was utilized by the HT Department to monitor staff competency with positioning, meals, oral care, bathing and lifting/transfers. This form was implemented in August 2012 for positioning (i.e. wheelchair, positioner, recliner and bed), meals, and lifting/transfers. Monitoring of positioning during medication administration started in January and bathing was initiated in June. The Compliance Monitoring form had instructions and identified additional indicators that were to be monitored for positioning (i.e., wheelchair, positioner, recliner and bed), lifting/transfer,	Noncompliance

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	implementing such plans.	and communication. However, there were no additional indicators developed for bathing and oral care. As a result of the absence of these discrete indicators on the monitoring form, it would not provide adequate information to identify issues that could be identified for individual and/or systemic change. Monitoring tools did not include adequate indicators to determine whether or not staff demonstrated competency in safely and appropriately implementing mealtime and positioning plans. Monitoring tools did not include adequate instructions. The staff responsible for monitoring included: three PTs, one PTA, four OTs, and three RDs. These monitors had completed competency-based training, performance check-offs, and achieved an inter-rater agreement of _85% and above. The process utilized to confirm monitors' competency was inter-rater monitoring. The staff conducting monitoring were competent in the areas they were monitoring. The monthly monitoring schedule was developed by the HT Administrative Assistant. Individuals at high risk received enhanced monitoring. This included the PNM risks of choking, aspiration, respiratory compromise, falls, fractures, and skin integrity. In future reports, the following indicators will be assessed: ▪ ____ of the ____ monitoring forms focused on oral intake (meals and snacks); ▪ ____ of the ____ monitoring forms focused on bathing; ▪ ____ of the ____ monitoring forms focused on medication administration; ▪ ____ of the ____ monitoring forms focused on oral care; and ▪ ____ of the ____ monitoring forms focused on positioning. ▪ ____% occurred during first shift; ▪ ____% occurred during second shift; and ▪ ____% occurred during third shift. In order addresses various types of risk, for the first five indicators, approximately 50 to 60 percent of monitoring should occur during meals, including individuals that are enterally nourished, with others evenly distributed; and monitoring should occur across all three shifts, with approximately 15 percent on third shift, and evenly distributed across first and second shifts. The Monitoring Team requested a list/spreadsheet/database report of individuals with completed monitoring for the past six months, including the type of monitoring (i.e., meal, bathing, transfer, etc.), date of monitoring, and the number of monitoring events that occurred on first, second and third shift. A review of the monitoring database from	

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		October 2012 to April 2013 found the following: ▪ The database did not identify on which shift the monitoring had occurred; ▪ No monitoring occurred in December 2012, January 2013, or February 2013; ▪ Monitoring for meals, positioning, lifting/transfers, mobility, and limited medication administration were monitored during this time period; ▪ The PNMP monitoring during this time period did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, such as bathing and oral care. Due to the absence of monitoring within these areas, issues might exist that had not been identified; ▪ The database did not identify for what type of positioning (i.e., wheelchair, bed, recliner, positioner) monitoring was completed; ▪ It was positive that the monitoring occurred in a variety of environments (i.e., bedroom, patio, dayroom, dining room, sensory room, workshop, living room, outside, education building); ▪ Starting in November 2012 a monthly compliance chart was completed that identified the compliance percentage for each of the ten questions on completed monitoring forms. There was no trend analysis of these results from month to month. In addition, there were indicators (i.e., number two, three, four, five, six, nine, and ten) that contained a subset of indicators a monitor was responsible for checking prior to scoring indicators. The HT Department should explore ways to have the monitor document which of the indicator subsets resulted in an indicator being scored no. This information should be tracked in the database to allow for an accurate trend analysis of staff noncompliance with PNMPs. ▪ An overall compliance score for the monitoring forms completed during the month were: o November 2012 overall compliance – 88 percent; o March 2013 overall compliance – 88 percent; and o April 2013 overall compliance – 42 percent. However, a review of the data did not support this low percentage. However, the HT Department should examine the usefulness of an overall compliance score, because it did not provide discrete data enabling the HT Department to identify staff noncompliance trends with the implementation of individual's PNMPs. **<u>Monitoring for Individuals in Samples</u>** The Monitoring Team was not able to score the following two metrics, because the frequency of monitoring was not established in policy, assessments and/or IHCPs did not indicate the frequency of monitoring: ▪ For _____ of the ____ (%) individuals in Sample 0.1, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' assessment and/or the individuals' plans/IHCPs.	

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		▪ For the three months prior to the review, ____ (0%) of the monitoring sessions per policy or the individuals' assessments and/or plans were completed timely. For none of four (0%) individuals in Sample O.2, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Monitoring should occur according to the schedule identified in policy and/or as individualized in the assessment and/or plan. In cases where the individual's clinical acuity necessitates a higher frequency of monitoring, it should occur at this frequency. The monitoring database did not provide sufficient data to assess the following: ▪ For the past three months, problems were noted on ____of the ____ monitoring forms. ▪ Of these, documentation of adequate follow-up was provided on ____ of the ____ forms that identified a concern. (0%). The Monitoring Team will assess this during upcoming reviews. "Adequate follow-up" should include plans with specific action steps that are measurable, and can be reasonably expected to correct the deficiency noted. The follow-up documentation should be included on the monitoring form. In addition, the Facility should be able to present cumulative monitoring data to substantiate compliance with these metrics. Additionally, observations the Monitoring Team completed in dining rooms and residences indicated staff were not correctly implementing PNMPs and dining plans for individuals. At the time of the Monitoring Team's review, the Facility did not have a policy and/or a procedure that described the current monitoring system to test staff's implementation of PNMPs, including their competence. As recommended in the Monitoring Team's previous reports, the HT Department staff should develop monitoring operational guidelines, to define the current monitoring system used 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.,	

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		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 demonstrate repeated staff non-compliance with PNMPs and therapy programs. In summary, the Facility had not yet developed and implemented a PNM monitoring policy with operational guidelines, including the necessary components. The HT Department was monitoring staff PNMP compliance, but additional work was needed as discussed within this section. The Facility remained out of compliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of Plans** None of the 15 (0%) individuals' records in Sample O.1 and none of four (0%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. None of the 15 (0%) individuals' records in Sample O.1 and none of four (0%) individuals in Sample O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. For none of the three (0%) individuals (i.e., Individual #66, Individual #317, and Individual #171) receiving direct therapy, the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan. Because plans did not include clinical indicators to alert teams to changes in status for the individuals in Sample O.1, the following metric could not be evaluated, but will be during upcoming reviews: ▪ _____ of the _____ individuals' records showed a change of status based on the established clinical indicators. Of these, ___ (__%) contained evidence that, as appropriate, the team met and interventions were reviewed and changed, as appropriate in a timely manner.	Noncompliance

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		Trigger sheets and supporting documentation was reviewed for individuals in Sample O.1. ▪ None of fifteen (0%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. A review of IRRFs did not reveal a discussion of the need for individualized triggers for individuals at high risk. ▪ None of fifteen (0%) individuals' Trigger sheets included individualized triggers as indicated. The trigger sheets reviewed had general triggers, but they were not individualized. In addition, individualized triggers on PNMPs were not reflected on trigger sheets. ▪ None of fifteen (0%) individuals' Trigger sheets were completed correctly. A review of trigger sheets revealed gaps in documentation on the three shifts. ▪ None of fifteen (0%) individuals' Trigger sheets were reviewed by the RN on a daily basis. A review of trigger sheets revealed gaps in documentation by direct support professionals and nursing. In summary, the Facility had not implemented an effectiveness monitoring system that included tracking of individualized clinical indicators and triggers to evaluate and report on the individuals' progress, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Assessment of Individuals Who Receive Enteral Nourishment** The Facility maintained a list of individuals who received enteral nourishment. However, a Facility policy and/or procedure did not define how the list of individuals who received enteral nutrition would be maintained and updated as individuals received a feeding tube and/or transitioned to oral eating. Based on a review of the ten individuals in Sample O.3 (Individual #181, Individual #317, Individual #199, Individual #281, Individual #100, Individual #161, Individual #269, Individual #324, Individual #21, and Individual #128), nine of nine (100%) individuals who receive enteral nutrition were evaluated at a minimum annually. Individual #317 received her feeding tube in June 2013, and so an annual evaluation was not yet due. None of the nine (0%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. In order to determine medical necessity of enteral nutrition, documentation should include the following areas: ▪ Nutritional assessment of current type of formula and schedule; ▪ Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and ▪ Assessment of Oral Motor status by SLP and/or OT to provide comparative	Noncompliance

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		analysis and safety of intake or development of an oral motor treatment plan, as appropriate. None of seven individuals (i.e., Individual #121, Individual #46, Individual #64, Individual #47, Individual #71, Individual #81, and Individual #83) admitted since the Monitoring Team's last review received enteral nourishment. Individual #197 and Individual #173 had been re-admitted to the Facility, but did not receive enteral nutrition. As a result the following metric was not reviewed: ▪ ____ of the ____ (%) individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** None of the nine (0%) individuals in Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. All individuals receiving enteral nutrition should be assessed annually by the IDT to determine if improvements can be made to progress towards a less restrictive diet. This means the individual should be: ▪ Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual is a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as part of assessment findings. ▪ Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings and determine if there is a possibility for modification to the least restrictive schedule. Justification for/or against medication of formula/schedule should be included as part of assessment findings. None of the two (0%) individuals (i.e., Individual #128 and Individual #199) who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. Based on information provided by the Facility, none of the two individuals had plans. The plan should include all of the following components: ▪ Staff training required prior to implementation; ▪ Staff roles and responsibilities (e.g., implementation and monitoring); ▪ Time and schedule of interventions; ▪ Specific triggers for when the plan should be stopped; ▪ Milestones for progressing with the plan; ▪ Documentation requirements (i.e., method for tracking progress); and ▪ Frequency of subsequent assessments and staff responsible.	

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		As a result, the following metrics were not evaluated, but will be, as applicable, during the upcoming reviews: ▪ ____ of the ____ (%) individuals' plans to return to oral eating were based on the results of the IDTs' discussion and integrated in the IHCP, ISP, and/or an ISPA. The IRRF should provide clinical assessment data to identify an individual's potential to return to oral eating and provide justification for the medical necessity of the feeding tube. Any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. ▪ ____ of the ____ (%) individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCPs should include timeframes consistent with the clinical needs of the individual. The IHCPs should be implemented according to the timeframes included, unless a reasonable explanation is provided. ▪ ____ (%) of the staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. Training conducted by the licensed clinician would include a return demonstration. ▪ ____ of the ____ (%) individuals' plans were monitored as outlined in the plan. Individuals' plans should be monitored to meet the frequency and requirements in the plan and should be conducted by monitors with demonstrated competency in the plan. ▪ ____ of the ____ (%) individuals' plans were modified by the IDT. For ___ (___%) of these individuals' plans, the IDT met, reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the plan is being implemented as written, staff are adequately trained, etc. In addition, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours or sooner if is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. The HT Department maintained an updated a list of individuals who received enteral nutrition. However, this process was not captured in Facility policy and/or procedure. Individuals in the sample who received enteral nutrition were reviewed by the IDT, but the annual assessment did not include necessary components. Individuals who were transitioning to oral eating did not have a formal oral intake plan that included the necessary components. The Facility remained out of compliance with this provision.	

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 For the following 15 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): (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, Individual #125, Individual #324, Individual #58, Individual #171, Individual #21, Individual #199, and Individual #100), 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 Health 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 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 issues, 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; 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 a wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices; o 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; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Compliance Monitoring form template; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ OT/PT assessments for new admissions completed after the submission of the pre-document request; ○ 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; ○ Denise Juarez, OT; ○ Stephanie Hernandez, OT; ○ Jon Olive, PT; and ○ Missy Olive, PTA. ▪ **Observations of**: ○ Individuals in residences and dining rooms.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 6/20/13. 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 P: ▪ Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well an interview with the Director of HT: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Compliance Monitoring tool, audits, and databases. The HT Department was not using the Settlement Agreement Monitoring Tool for Section P. ○ The Compliance Monitoring tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. However, the data presented in the Self-Assessment reflected the completion of additional activities and audits, such as OT/PT assessment audit tool, review of OT/PT assessments for new admissions, HT spreadsheet report for ISP attendance, ISP audits, etc. The data presented represented a positive move forward in monitoring compliance with Section P. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. ○ The Self-Assessment identified the sample sizes, and how the sample was chosen. ○ The 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 tool: the Director of HT, therapy staff, and the PCM. o Adequate inter-rater reliability had not been established between the Director of HT, therapy staff, and the PCM. ▪ The Facility used other relevant data sources, including, for example, information from the HT Department databases and/or spreadsheets. ▪ The Facility presented some data in a meaningful/useful way, but in other instances more work was needed. 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. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Sections P.1 and P.3. The Monitoring Team did not find the Facility in compliance with these sections. In Section P.1, individuals' OT/PT assessments required additional work to ensure necessary components were present, and some individuals who had experienced a change in status had not received an assessment update. For Section P.3, additional work needed to be completed for individual-specific training. The Facility rated itself in noncompliance with the remaining subsections (i.e., Sections P.2 and P.4). These findings were 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 seven individuals newly admitted to the Facility received an OT/PT assessment within 30 days. However, individuals who had experienced a change in status had not received an assessment update. Individuals' OT/PT assessments were missing some of the components necessary to fully assess an individual's OT/PT functional status, provide an analysis of whether or not current supports and services were effective, and as appropriate, recommend new services or skill acquisition programs to improve the individual's functioning, health, and/or independence. Individuals receiving direct OT/PT interventions did not have plans. As a result, these plans and/or programs were not integrated into individuals' ISPs. In addition, there were no monthly progress notes reviewing the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports. As discussed with regard to Section O.6 and O.7, the Facility did not have an adequate monitoring system for OT/PT services. The Facility did not have a policy to define the monitoring system. On a positive note, the Facility was tracking the completion of requested wheelchair repairs.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of 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.	**Definition of Samples** ▪ **Sample P.1** consisted of a non-random sample of 10 individuals (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, Individual #324, and Individual #58) who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, and/or osteoporosis], required mealtime assistance, and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to an emergency room and/or hospital). Individuals within this sample might have met one or more of the preceding criteria. ▪ **Sample P.2** consisted of three of the nine individuals (i.e., Individual #317, Individual #66, and Individual #171) who received direct OT/PT services. **Timeliness of Assessments** Seven of seven (100%) newly admitted individuals (i.e., Individual #121, Individual #46, Individual #64, Individual #47, Individual #71, Individual #81, and Individual #83) since the last review received an OT/PT assessment within 30 days of admission or readmission. Nine of 10 (90%) (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #324, and Individual #58) individuals' OT/PT assessments and/or updates were dated as having been completed at least 10 days prior to the annual ISP. Ten of 10 (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **OT/PT Assessment** Based on review of the sample of 10 assessments for individuals in Sample P.1 (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, Individual #324, and Individual #58), the comprehensiveness of the OT/PT assessments was as follows: ▪ Ten of 10 (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Eight of 10 (80%) (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) assessments included medical diagnoses and relevance to functional status.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Eight of 10 (80%) (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) assessments included medical history and relevance to functional status. The medical history refers to medical conditions that would impact the provision of OT and PT supports and services. ▪ Eight of 10 (80%) (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) assessments addressed health status over the last year. ▪ Seven of 10 assessments (70%) (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, and Individual #324) included a comparative analysis section that clearly analyzed the individuals' level of health status with previous years or assessments. The OT/PT assessment should provide an overview of an individual's health status over the past year and discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status. ▪ Ten of 10 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. ▪ None of 10 (0%) assessments listed medications and potential side effects relevant to functional status. ▪ Nine of 10 (90%) individuals' OT/PT assessments (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) included individual preferences, strengths, and needs. ▪ Ten of 10 (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Two of 10 (20%) (i.e., Individual #66 and Individual #269) individuals' OT/PT assessments included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ Nine of the ten individuals used a wheelchair as a primary mobility device (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, Individual #324, and Individual #58). Eight of the nine assessments (87%) (i.e., Individual #181, Individual #317, Individual #281, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) included a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. ▪ None of 10 assessments (0%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings.	

#	Provision	Assessment of Status	Compliance
		▪ Ten of 10 assessments (100%) included recommendations for services and supports in the community. ▪ Three of 10 (30%) assessments (i.e., Individual #181, Individual #317 and Individual #324) included a comparative analysis of current functional motor and activities of daily living skills with previous assessments that clearly analyzed the individuals' level of functional status with previous assessments. The OT/PT assessment should provide an overview of the past assessment results with the current assessment data for functional motor and activities of daily living skills. The assessment analysis should discuss the individual's performance and present data to support if the individual has remained the same, has improved, and/or has regressed within the areas of functional motor and activities of daily living. ▪ Nine of ten assessments (90%) (i.e., Individual #181, Individual #317, Individual #281, Individual #20, Individual #66, Individual #161, Individual #308, Individual #269, and Individual #324) included documentation of the efficacy and/or introduction of new supports in the PNMP which addressed the individuals' PNM risk levels; ▪ Four of 10 (40%) assessments (i.e., Individual #181, Individual #66, Individual #308, and Individual #58) included discussion of the individual's potential to develop new functional skills. The OT/PT assessment should discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs. ▪ Ten of 10 (100%) assessments identified the need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. The OT/PT assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs. ▪ None of 10 (0%) assessments included a monitoring schedule. The OT/PT assessment should recommend a monitoring schedule for the upcoming year as these individuals had PNMPs. The therapist should describe the monitoring form(s) to be utilized. ▪ Ten of 10 (100%) assessments included a reassessment schedule. ▪ Ten of 10 (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. As required by State Office, therapists had included their opinion about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needed were missing in the community. ▪ None of 10 (0%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day.	

#	Provision	Assessment of Status	Compliance
		There were two individuals (i.e., Individual #66 and Individual #58), who had experienced a change in status (i.e., Modified Barium Swallow Study and choking incident) after the completion of these individuals' comprehensive OT/PT assessments. These individuals should have received an assessment update and/or consultation, but they did not. More specifically: ▪ Individual #66 received a Modified Barium Swallow Study on 2/14/13. She had not received an assessment of status and/or consultation to address the reason and/or the results of the MBSS. ▪ Individual #58 experienced a choking incident on 5/5/13. He had not received an assessment of current status and/or consultation to address his change in status. The following metric could not be assessed due to the fact that assessment updates had not been completed: ▪ For _____ of ___ (0%) individuals for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. In summary, individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Individuals' OT/PT assessments required additional work to ensure necessary components were present. The OT/PT assessment template and audit tool should be reviewed to ensure the components for OT/PT assessments are incorporated. Individuals who had experienced a change in status had not received an assessment update. The Facility remained out of compliance with this provision.	
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	**Direct OT/PT Interventions** Nine individuals received direct OT/PT intervention. Sample P.2 was comprised of three of these nine individuals (i.e., Individual #317, Individual #66, and Individual #171). The records of these individuals were reviewed resulting in the following findings: ▪ For none of three (0%) individuals' direct intervention plans could it be determined if they were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. ▪ For none of three (0%) individuals' records reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. The OT/PT assessment did not include an analysis of assessment data to provide justification for initiation of the direct therapy intervention.	Noncompliance

#	Provision	Assessment of Status	Compliance
	aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	▪ For none of three (0%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ None of these individuals' therapy had been terminated. In future reports, the following will be assessed for individuals whose direct therapy has been terminated: For _____ of _____individuals' records whose therapies had been terminated (%), termination of the intervention was well justified and clearly documented in a timely manner. The therapist should provide clinical justification for the termination of a direct intervention plan. The team should discuss the recommendation to terminate the program within 10 working days, and the team's decision should be documented through an ISPA meeting. **Indirect OT/PT Programs** The implementation of these plans is discussed with regard to Section O.4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** Five of the 10 individuals' annual ISPs in Sample P.1 (50%) (i.e., Individual #317, Individual #281, Individual #66, Individual #161, and Individual #269,) noted that the OT or PT attended the ISP or ISPA meeting. An OT attended for Individual #317, Individual #281, Individual #161, and Individual #269. A PT attended for Individual #317, Individual #281, Individual #66, and Individual #269. No OTs and/or PTs attended for five individuals (i.e., Individual #181, Individual #20, Individual #308, Individual #324, and Individual #58). The Pre-ISP meeting documentation required attendance for the OT and PT for Individual #181, but no OT and/or PT attended. There was no Pre-ISP meeting conducted for Individual #20, Individual #66, and Individual #269. In other cases, the Pre-ISP meeting did not require attendance for an OT and/or PT, but adequate justification was not provided (i.e., Individual #181, Individual #66, Individual #161, Individual #308, Individual #125, Individual #324, and Individual #58). Per current 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 individuals' care and treatment do not need to attend. Generally, for individuals receiving direct therapy, the therapist should attend the meeting. Three individuals in the sample had received direct therapy (i.e., Individual #317, Individual #66, and Individual #171). An OT and/or PT attended these individuals' annual ISP meeting.	

#	Provision	Assessment of Status	Compliance
		For individuals receiving OT/PT supports and services, 10 of 10 (100%) PNMPs were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. Five individuals in Sample P.1 had their PNMPs revised after the annual ISP meeting (i.e., Individual #317, Individual #281, Individual #161, Individual #308, and Individual #58). For two of five individuals (i.e., Individual #161 and Individual #58)(40%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment. Individual #317, Individual #281, and Individual #308 did not have an ISPA addendum and/or email confirmation to IDT members that the PNMP had been revised. Three of the 10 individuals' OT/PT assessments recommended skill acquisition programs (i.e., Individual #66, Individual #308, and Individual #58). In two of the three (67%) (i.e., Individual #66 and Individual #308) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. For three of three individuals (i.e., Individual #66, Individual #308, and Individual #58) (100%), the ISP/ISPAs contained measurable objectives related to interventions. None of the three (0%) individuals receiving direct OT/PT services was provided with comprehensive progress notes (IPNs) at least monthly. The progress notes should: ▪ Contain information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); ▪ Describe the benefit of the goal to the individual; ▪ Report the consistency of implementation; ▪ Identify recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress; and ▪ Be completed on at least a monthly basis. Based on the therapist's monthly data, if a lack of progress is noted, team review should occur to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. For individuals with PNMPs or SAPs (i.e., indirect OT and/or PT programs), for none of the 10 individuals (0%), monthly documentation from the OT and PT and/or QDDP was present, including the following: ▪ Information regarding whether the individual showed progress with the stated goal(s), including a summary of clinical data to substantiate progress and/or lack of progress with the therapy goal(s); ▪ A description of the benefit of the program;	

#	Provision	Assessment of Status	Compliance
		▪ 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. Individuals receiving direct OT/PT intervention did not have plans and comprehensive progress notes. The Facility remained out of compliance with this section.	
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.	The requirements for this section were discussed in detail with regard to Section O.5.	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 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.	**<u>Monitoring System</u>** The Facility did not implement a system for the adequate monitoring of PNMPs. Monitoring of PNMPs is discussed in detail with regard to Section O.6. The Facility submitted the following policies: ▪ LBSSLC – IDT – Program Development: OT/PT Services, Assessment, Update and Consultation Process, revised 2/16/10; ▪ The preceding policy referenced the State Supported Living Center Policy: Occupational/Physical Therapy Services, Policy 014, dated 10/7/09; The elements that are underlined below were covered in the State and/or Facility OT/PT policy. The Facility PNM policy should address the remaining components that are listed, but not underlined below: ▪ <u>Description of the role and responsibilities of OT/PT;</u> ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identification of monitors and their roles and responsibilities; ▪ Definition of a formal schedule for monitoring to occur;	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identification of the frequency of assessments; ▪ Definition of how individuals' OT/PT needs will be identified and reviewed; and ▪ Requirements for documentation expectations for individuals receiving direct services. Based on documentation submitted, it could not be determined if positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. Routine maintenance checks were completed for individuals' wheelchairs. However, the Facility did not submit documentation to substantiate routine maintenance checks for all other PNMP prescribed equipment. There was no database to track the completion of work orders for individuals' assistive equipment. The Facility should define through protocols what information will be presented in reports taken from a database and how plans of correction will be developed to resolve problems. These reports should provide information to substantiate compliance within this section. . It should be noted that the Facility submitted completed Wheelchair Repair Requests for June 2013. There were 102 wheelchair repairs completed. None of these repairs exceeded 30 days for completion. The majority of repairs were completed on the same day a request was made for repair. One hundred forty-two of 142 individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days unless justification was provided, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. In summary, as discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for individual OT/PT needs including a review of individual's assistive equipment. The Facility did not have a policy that adequately defined the monitoring system. On a positive note, the Facility was tracking the completion of requested wheelchair repairs. The Facility remained out of compliance with this section.	

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 List of staff in the Dental Department, including names, title/role, and degrees; o List of staff in the Dental Department and their CPR certification status; 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 documentation confirming 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 and other dental visits in prior six months for one individual from each residence. A copy from Dental Department's record of visit and copy from active record of same visit, including source of documentation (i.e., IPN or dental section of active record/Dental Department record); o Five most recent off-site oral surgery consults and progress notes for 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 (i.e., prophylaxis, annual, etc.), name, 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 Monitoring Team's 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, i.e., prophylaxis, annual, etc.); o List of no shows/missed appointment per residence per month for the last six months; o List of refusals per residence 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 and other dental missed appointments; o For five most recent emergency exams, IPNs from start of emergency to closure, and copy of Dental Department evaluation and treatment including time and date of first symptom/concern, and time/date first seen in the Dental Department; 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 five 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 (e.g., medical, anesthesia clearance, etc.), and post-operative checklist or monitoring forms, IPNs on date of procedure, etc.; o For the past six months, copies of any correspondence concerning restraint and sedation use at time of office visit (e.g., to QDDP, team, psychologist, etc.); o In response to request for individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and Dental Department from start of sedation in residence (if applicable) to release from monitoring (including pre-treatment sedation sheets); o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as by mouth (PO) sedation, Intravenous (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 such as lower dosage, less mechanical restraint duration, etc.); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV

	sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure; 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 the Monitoring Team's visit (i.e., 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 of these same individuals; o Dates 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 and odontogram; o Copy of 10 most recent annual dental summaries provided for the ISP; o The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, and poor ratings, with date of data; also, a list of individuals for whom an oral hygiene rating was not obtained during this time; o For those individuals for whom care plans/ISP indicate they brush their own teeth, the oral hygiene scores, with dates of the scores, over the prior one year; 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 individuals that brush their own teeth, but do not floss, the reason for not flossing their own teeth. Requested information as to whether a skill acquisition plan had been created or implemented for flossing; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list of reasons for not using dentures, with documentation as indicated; o Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.; o For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24-hours following TIVA administration in prior six months; o For those with documented pneumonia, for each individual, date pneumonia documented, date of the most recent dental visit prior to the pneumonia, type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater

	reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process, a list of the databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and for data collected periodically rather than continuously, the frequency of data collection; o Presentation Book for Section Q; o Date range of individuals without radiographs; o Number of individuals seen in the hospital by month for the last six months for dental procedures; o Last two annual oral hygiene reports for individuals that brush their own teeth; o No-show dates listed for individual that was not seen for initial exam within 30 days; o Training material used for Dental Hygiene Training; and o Training rosters past six months for dental hygiene for individuals and direct support professionals. ▪ **Interviews with**: o 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: o The monitoring/audit tools the Facility used to conduct its self-assessment included: "Section Q Monitoring Tool with the Dental Database." o These monitoring/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. o The monitoring tools included adequate methodologies, such as record 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). These sample sizes were adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: QA Department staff. o Based on their experience and credentials, they likely 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. ▪ The Facility did not use 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. The quality of the data maintained in the databases was noted to be incomplete and inaccurate. ▪ In some instance, the Facility presented data in a meaningful/useful way, but some concerns were

	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 (i.e., such as completion of annual dental summaries based on outdated annual dental examinations, completeness of information on the annual dental examination, periodontal condition, tracking steps to reduce the missed appointment rate, etc.) o Data was only collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being noncompliant with Sections Q.1 and Q.2. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, but this did not result in corrective action plans for all areas needing improvement.
	Summary of Monitor's Assessment: The Dental Department continued to provide a full array of dental services. There were no adverse events following total intravenous anesthesia (TIVA)/general anesthesia administration. A flossing program was started with three individuals. A small percentage of the population was edentulous. The new dental database software appeared to be functional. There was a high rate of individuals that brushed their own teeth. There continued to be numerous challenges. The annual examination reports did not include meaningful dental treatment plans. At times, the annual dental summary was based on outdated annual dental assessments. There was no Dental Department quality improvement initiative. Review of dental services was only accomplished through the QA Department. For those identified as needing or benefitting from a suction tooth brushing, but without access, there did not appear to be a quick resolution in obtaining the equipment and resolving the challenges. Some follow-up visits for missed appointments appeared delayed for months. The Dental Department did not aggressively resolve the many refused and missed appointments. There remained many policies and procedures in draft form. For the prior six months, there were 307 completed dental appointments. Although none of the appointments utilized mechanical restraints, and only one utilized oral sedation, 60 appointments (20%) utilized general anesthesia/TIVA. The risk/benefit of oral sedation versus TIVA/general anesthesia was not well defined. It appeared that the Dental Department considered TIVA/general anesthesia less of a risk to administer than any level of oral sedation. Rationale of risk/benefit needed to be documented and supported by dental references and standards. Rationale of least restrictive approach using oral sedation versus TIVA/general anesthesia also needed documentation. Due to these numerous challenges, the Dental Department was in noncompliance with Sections Q.1 and Q.2.

#	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.	<u>Staffing</u> The Dental Department staff included two Dentists (one full-time and one half-time), one Registered Dental Assistant, and one Dental Clinical Hygienist. There was a clinical manager who also held the title of Dental Assistant. There was one vacancy for a Dental Assistant. CPR certification was submitted for the Dental Department staff. For the four clinical dental staff, four (100%) were current in CPR. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from December 1, 2012 through June 18, 2013. The document was entitled "LBSSLC Current and Previous Annual Assessments Completed." This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from the list. The list included names of 109 individuals. Two of these did not list previous annual examination dates and were removed. Eight were new admissions during the time period for the data submitted and were removed. Of the remaining 99 individuals, 86 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 87%. There were 13 overdue annual examinations. All of the overdue exams were due to isolation in the residences. From a submitted document entitled "LBSSLC Current Enrollment with no Dental Services Over One Year," the Dental Department documented that there were no individuals residing at LBSSLC who had not seen a dentist in the prior year. Separately, copies of 10 annual dental assessments/examinations (entitled "dental record: annual examination") completed in the 30 days prior to the Monitoring Team's visit, along with the prior year's completed assessments, were submitted. For 10 out of 10 (100%) of these individuals, an annual dental assessment had been completed within 365 days. For the annual dental assessments, each current and prior assessment listed level of cooperation, oral hygiene rating, periodontal type and periodontal risk, as well as examination of extra oral and intra oral tissues. Oral cancer screening was not located on this form, but was located on a separate stamped form on the Dental Progress Note (DPN) and IPN. Positioning for exam, oral hygiene recommendations, risk rating for the IRRF, and community transition recommendations were not located on the annual dental assessment. The dental treatment plans submitted were logs of dental exams, but did not indicate whether referrals for procedures under TIVA/general anesthesia had been completed. These plans did not reflect the recommended treatment in the annual dental	Noncompliance

#	Provision	Assessment of Status	Compliance
		summaries. The odontograms (black and white copies) at times were of poor quality, and it could not be determined if all were completed. The annual dental assessment did not readily indicate the number of teeth nor the number of restored teeth, and the treatment plan did not indicate future steps, concern for periodontal status, need for further dental work (i.e., extractions, restorations, etc.), nor recommendations for brushing or toothbrush instructions to the direct support professional or individual, as applicable. As noted below, the annual dental summary appeared to be more complete than the dental annual assessment/examination for several of these areas. The annual dental summary appeared to use a computerized format and the dental record annual examination required manual completion of a document. Overall, considerable information was missing from the "dental record: annual examination." As noted below, the annual dental summary referred to the last completed annual dental examination, which at times had been completed months in the past, and relied on details recorded in the annual dental examination. Copies of 10 annual dental summaries were submitted for review. The content of the annual dental summary included the following components: ▪ Ten of the 10 (100%) submitted annual dental summaries had an entry concerning behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) submitted summaries had entries for oral hygiene rating. ▪ Nine of the nine (100%) submitted summaries for individuals with teeth had entries for periodontal status. ▪ One individual was edentulous. ▪ Ten of the 10 (100%) submitted summaries had entries for examination of the oral cavity tissues. ▪ A specific notation concerning oral cancer screening (intra-oral exam and extra oral exam screening) was not indicated in the format utilized. This was located in the annual exam stamp in both the IPN and DPN. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in zero of nine (0%) records. This was due to the assumption that the majority of the individuals have active periodontal disease. Based on this information, pocket depth measurements would be of little or no value, according to the Dental Department. It was unclear how the Dental Department measured impact/effectiveness of dental prophylaxis, tooth brushing instruction to staff and individuals, therapeutic mouthwashes or antibiotics, or more complex procedures and dental services on periodontal disease. The records provided no evidence of monitoring of periodontal disease to ensure improvement and prevent deterioration. It is recommended that the Dental Department provide references for dental care standards for not measuring and tracking periodontal disease in this population at high risk for periodontal disease and tooth loss.	

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		▪ Ten of the 10 (100%) submitted summaries documented a completed odontogram findings/treatment during the annual visit, with color-coding. One of the odontograms appeared to have incomplete information. ▪ Ten of the 10 (100%) submitted summaries included a dental treatment plan/recommendations. ▪ Ten of the 10 (100%) submitted summaries documented oral hygiene recommendations. ▪ Ten of the 10 (100%) submitted summaries documented risk rating specific to periodontal disease and caries. ▪ Zero of the 10 (0%) documented the risk according to the risk guidelines developed by the State Office and documented in the IRRF. ▪ Ten of the 10 (100%) submitted summaries documented community transition preparedness. ▪ For seven of 10, the date of the annual dental summary was months to years after the last annual dental assessment. In addition, the dental summary did not highlight the fact that it was based on a dental assessment significantly in the past. This would be important in guiding the IDT to determine steps to resolve this concern and to ensure a successful annual assessment. Basing the data in the dental summary on outdated information could be clinically misleading. For example, in one summary, the date of the last annual dental assessment was 11/29/11, and for one individual, the last successful annual examination was not recorded, and only the three most recent attempted appointments were included, dating back to July 2012. For one individual, the completed annual occurred a month after the annual dental summary was completed. As the annual dental summary was dated prior to the most recent annual examination, the date of the summary indicated it did not include recent examination findings. The reason for not creating an updated annual dental summary at the time of the annual dental examination was not clear. Given that the ISP process requires a current annual dental summary within 10 days prior to the ISP, the annual dental summary should not be created based on old information, but the Dental Department should request at the pre-ISP meeting that the IDT prioritize its efforts in ensuring a successful annual dental examination is completed within 30 to 60 days prior to the ISP. When the annual dental summary is based on examinations more than three months in the past, the fact that information may not be current and should be highlighted for IDT knowledge. The impact of the annual dental summary being created on outdated information is a concern. When an individual has anorexia or difficulty eating, or new behaviors, the IDT would reference the annual dental summary. However, although the date of the summary might be current, unless one	

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		reviews for more detail, one would miss that this information is not derived from an exam on that date, but based on information from an annual exam months to over a year earlier. Although the individual might have dental or gum discomfort, this might be dismissed, because the dental summary was not based on recent information. Copies of the most recent comprehensive assessments and other dental visits in prior six months for one individual from each residence were requested. This was to include a copy of each document from the Dental Department record and a copy from the active record for the same visit, with further identification on each document submitted as to its source: the Dental Department record, or IPN/dental sections of the active record. It was emphasized that the source of the document submitted be provided. This was to determine whether all significant information (with exceptions such as actual dental x-rays) in the Dental Department record was located in the active record for IDT access. Copies of dental records for 15 individuals were submitted. Several documents were submitted for each individual, as applicable. These included a copy of the annual medical summary and physical examination, dental consents, human rights approval, the prior two annual dental summaries, dental progress notes from the prior six months, IPNs from the prior six months, and a copy of the anesthesia record. However, the source of the submitted documents was not included for any records (i.e., Dental Department record, active record IPN, active record dental section.) Further analysis of this section could not be completed. It could not be determined whether all applicable Dental Department documents for individuals were copied and located in the active record. <u>New admissions</u> During the time period from 12/1/12 through 6/18/13, there were eight new admissions. Seven out of eight (88%) had completed an initial dental exam in the first 30 days (from two to 28 days). One individual did not complete an initial assessment until the 72nd day of admission. For the individual with a delayed initial exam, a copy of the dental progress note was submitted, indicating that appointments were scheduled for 1/24/13, 2/7/13, and 2/27/13, but that behavioral problems prevented the appointment from occurring. There was no further information recorded in the dental progress record as to any action the Dental Department took, such as providing a home visit for the initial visit at a time of the day when the individual might be calm, etc. Additionally, there was no entry or signature on the dental progress note by a dentist to confirm the dentist was aware of the delay in completing an initial dental assessment. The information on this submitted page could not be verified. Two submitted documents, including "LBSSLC All Missed and Refused Dental Appointments Reporting Dates 11/1/12 - 5/15/13," and "LBSSLC Dental Appointments Attendance Sheet Reporting Dates: December 1, 2012 – June 18, 2013," did not include this individual in	

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		the list of refused, missed, or cancelled appointments. The second document ("LBSSLC Dental Appointments Attendance Sheet Reporting Dates: December 1, 2012 - June 18, 2013") did list a completed appointment on 3/19/13, which was after the thirty day time period, however, from these two lists of missed and refused appointments, it appeared an initial visit was not offered during the first 30 days. The two sets of submitted information appeared to provide conflicting information. <u>Oral Hygiene</u> The most recent oral hygiene scores were submitted for the entire campus, in a document entitled "LBSSLC Current Enrollment – Oral Hygiene, Reporting Dates 5/30/13." Seven categories/ratings of oral hygiene were provided. Information was based on a census of 215 individuals. For 30 individuals (14%), no rating was on file. Additionally, 13 individuals (6%) were edentulous and ratings were not provided for these individuals. No individual had an oral hygiene score of excellent, or good to excellent. Forty-eight individuals (22%) had a good oral hygiene score, 10 individuals (5%) had a fair to good oral hygiene score, 85 individuals (40%) had a fair oral hygiene score, seven individuals (3%) had a poor to fair oral hygiene score, and 22 individuals (10%) had a poor oral hygiene score. Attached was a listing of the dental visits for the past year. Many individuals had serial oral hygiene scores for the past year. It was not clarified whether the score used in the report was the most recent score, or the best score during the prior year, or an average of scores available. It is recommended that this information be provided with the reports generated for oral hygiene ratings. Starting in January 2013, the Dental Department began to track oral hygiene scores per month. From the information provided, it appeared that scores were obtained from any dental visit (e.g., preventive, examination, TIVA, restorative, etc.) that occurred in that month. It was not clear if there were dental visits in which oral hygiene scores were not obtained. It was stated in the January 2013 report that the goal was 85 percent of the individuals at LBSSLC would have fair or good ratings. The January 2013 data indicated that 78 percent attained that rate. For February 2013, the percentage with fair or good oral hygiene ratings was 66 percent. The change from the prior month might have been due to the increased number of edentulous individuals completing an annual exam that month. The March 2013 data indicated a further drop to 64 percent. It was believed this further drop was due to the reduced number of appointments in the dental clinic that month due to reduced Dental Department staffing. For April 2013, 72 percent of individuals had fair or better oral hygiene scores. The Dental Department listed two programs, which were either in the planning stages or had been implemented. These were designed to improve oral hygiene. The Dental Toothbrush program was implemented as of 6/1/13. A brief description of this program was provided, and included identification of residences with the largest	

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		numbers of individuals with poor hygiene as a priority focus. The hygienist was to spend one afternoon a week in a residence, providing onsite training and reinforcement of oral hygiene care to the individuals and staff. The hygienist was to provide oral care instruction in each residence over the next six months. This showed a valuable use of the data, and the proposed remedy seemed reasonable. Continued tracking of outcomes will be important to determine if full implementation occurs, and whether it has the desired impact. The other program mentioned was the suction tooth-brushing program. However, no details were provided as to content or when it would start. <u>Oral Hygiene Training</u> According to the Dental Department, each prophylactic care visit included oral hygiene instruction to either the individual or the direct support professional or both. The Dental Department indicated the number of oral hygiene instructions in the Dental Department was the number of prophylactic care visits. This totaled 121 oral hygiene instruction events from 12/1/12 through 7/11/12. It is recommended that oral hygiene instruction be recorded at any dental visit in which it occurs. Additionally, the Facility maintained a training roster entitled: "Active Employee Course Participation Report" (dates of 11/1/12 - 7/31/13) for the course "Oral Care – Dental Care." This document indicated that 128 staff had completed training on this topic. A copy of a training manual, entitled "Oral Care" was submitted, which appeared to be a PowerPoint presentation the Dental Department provided to the Facility employees. <u>Suction Tooth-brushing</u> As part of preventive oral care, suction tooth brushing reportedly was available to those with one or more of the following indications for this procedure: risk of aspiration, history of aspiration, risk of silent aspiration, unable to manage thin liquids safely, unable to spit, and unable to brush independently. A list submitted indicated 61 individuals received suction tooth brushing, which was 29 percent of the population. Thirty-three additional individuals were identified as qualifying for suction tooth brushing, but resided in residences without the required equipment. These residences were #526 (Tulip), #517 (Maple), #527 (Iris), #518 (Oak), #523 (Violet), and #520 (Willow). Reasons included limitations of electrical outlet access, space in the homes for the equipment, teaching of new nursing and selected direct support professional staff, and delays in equipment requisitions. <u>Individuals with self brushing plans</u> The Dental Department submitted a document dated 5/30/13 which listed 74	

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		individuals that brushed their own teeth. The oral hygiene scores of these 74 individuals were requested for the prior two ratings completed at the time of the annual exam. For the first set of submitted data, the oral hygiene ratings for the prior two annual dental assessments were not provided. A series of ratings over the past several months were included, but the data was not aligned in the chart to determine the ratings for each individual. For some individuals, only one rating was listed. After discussion with the Dental Director, an additional report was submitted, which listed two oral hygiene scores from six to 12 months apart, to determine progress or trend in oral hygiene scores for this population. Review resulted in the following information: ▪ Thirty-nine individuals remained in the same category of oral hygiene rating. o There were two individuals that maintained a good oral hygiene rating. o For thirty-three, the individuals maintained a fair oral hygiene rating. o For four, the individuals continued to have poor oral hygiene ratings. ▪ For these four individuals, it was not determined whether the IDT and/or the Dental Department had identified the need for additional assistance/steps or review of the plan for brushing one's own teeth. ▪ For 20 individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. o For five individuals, the ratings improved from poor to fair. o For 13 individuals the ratings improved from fair to good. o For two individuals, the ratings improved from poor to good. ▪ For 13 individuals, the oral hygiene ratings worsened o For zero individuals, the rating changed from good to poor. o For six individuals, the ratings changed from good to fair. o For seven individuals, the ratings changed from fair to poor. It was not determined whether the IDT and/or Dental Department had identified this worsening in oral hygiene rating and whether steps had been taken to address this decline. <u>Flossing</u> The Dental Department submitted a document entitled "Individuals that floss their own teeth" (dated 5/30/13), which listed three individuals that "recently" started a tooth-brushing/flossing program. To date, tooth brushing had improved for these three individuals and they had started flossing. From a separate document entitled "Individuals provided flossing instructions" (dated 6/1/13), flossing instruction occurred on 5/9/13 and 6/13/13. From a document entitled: "Individuals that brush on their own" (dated 5/30/13), a list of those individuals with independent tooth-brushing skills was provided, along with the reasons for those individuals not being able to floss independently or with	

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		assistance. It was noted that one individual flossed (i.e., one of the three listed in the prior document). It was documented that 40 individuals could floss, but that 39 were not flossing. Skill acquisition plans were in place for none of these 39 individuals. It was documented that 30 other individuals were unable to floss. Reasons provided included: pica and lack of dexterity. From an updated list "Individuals That Brush On Their Own," undated but submitted the week of the Monitoring Team's onsite visit, there were 44 individuals identified that were able to floss, but only one individual was flossing. It was also noted that for those that had self tooth brushing skills, a date of oral hygiene instruction was listed for 71 of 74 individuals. According to the Dental Department, as noted previously, oral hygiene instruction was provided at each preventive care visit. This training also included instruction for flossing to both individual and staff at each preventive care visit. <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from 11/17/12 through 4/29/13, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. Of a list of 15 individuals that had a diagnosis of pneumonia 21 times, zero individuals had dental appointments within eight days prior to the date of the pneumonia diagnosis. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department did provide the breadth of services required to care for the individuals at LBSSLC. From 12/1/12 through 6/18/13, 87 individuals (duplicate count) were seen for prophylactic care. From a document entitled: "LBSSLC Preventative Dental Care, Reporting Dates 12/1/12 - 6/18/13," these visits occurred as prophylactic care only treatment or as a combination of other dental services (i.e., annual assessments, x-rays, topical fluoride treatment, etc.). The data included refused or incomplete visits, and some visits did not specifically list prophylaxis. There also appeared to be duplication of visits listed, as several were listed as seen within 24-hours of a prior visit for prophylactic care. In these cases, one of the visits was removed from the total count. The following was the breakdown per month of the number of prophylactic care treatments completed: **Month** / **# Prophylactic Care Treatments** December 2012 — 10 January 2013 — 9 February 2013 — 11 March 2013 — 6 April 2013 — 18	

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May 2013	19
June 2013	14
Total	**87**

Eighteen individuals underwent restorative care during 20 appointments. The following was the number of visits each month:

Month	# Restorative Appointments
December 2012	4
January 2013	5
February 2013	2
March 2013	3
April 2013	4
May 2013	2
June 2013	0
Total appointments:	**20**

Nine individuals were seen and treated for 10 dental emergencies. For these 10 dental emergencies, six individuals complained of pain or discomfort. The dentist documented the presence of pain in two individuals and prescribed pain medications. There was documentation that pain medication was not needed in six cases. For two individuals, the emergency log did not indicate whether pain medication was prescribed. Four individuals were scheduled for TIVA. One individual was referred to an endodontist. One individual was scheduled for an extraction.

Eleven individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to seven per visit. Six individuals had one tooth extracted. Four individuals had two teeth extracted, and one individual had seven teeth extracted.

From a submitted document entitled "LBSSLC Current and Previous Annual Assessments Completed Reporting Dates: December 1, 2012 – June 18, 2013," dated June 18, 2013, 109 individuals completed an annual/initial dental exam from December 1, 2012 through June 18, 2013. These annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. The following number of annual exams were completed per month:

Month	# of Completed Annual Exams
December 2012	1
January 2013	27
February 2013	32

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March 2013	11
April 2013	2
May 2013	35
To June 18, 2013	1
Total	**109**

X-rays

According to the Dental Department, as of 5/30/13, nine individuals needed or were overdue for recommended dental x-rays. All needed a full mouth radiograph series in a hospital setting because of medical needs. Information concerning the date of the last radiograph was submitted for seven of these individuals.

Two individuals had documentation of x-rays in the past. Both were completed prior to 2000. For five individuals, the Dental Department had no record of x-rays being completed. Dates of admission to LBSSLC for these five individuals ranged from 1970 to 2003.

Edentulous individuals/dentures

Information submitted in a document entitled "Edentulous since Last Visit, May 30, 2013," indicated 15 individuals residing at LBSSLC were edentulous, for a rate of 15 out of 211 (7%). No individual became edentulous in 2012. None became edentulous since January 1, 2013. The following lists the year in which edentulousness occurred or was first documented.

Year edentulous occurred or first recorded	# Individuals
2013	0
2012	0
2011	2
2010	3
2009	1
2008	3
2007 or prior	6

However, an untitled document listed names of individuals that were edentulous, whether dentures were being used, and additional information for each, providing reasons for not having dentures, if applicable. On closer review, the left hand column provided a number of 19, but it was not clear what the number referenced, and some numbers were missing (#4, #11, #15, #16). Fifteen individuals were listed in the column naming the individuals. From this information, it could be determined that two

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		of 15 individuals that were edentulous had dentures and thirteen individuals that were edentulous did not have dentures. Under the last column entitled "Additional information," comments for 17 individuals were provided. It appeared that two individuals in this section were not referenced elsewhere. From this column, there were two individuals with dentures and 15 individuals without dentures. Reasons given for not having dentures were: ▪ Challenging behavior for wearing dentures – one; ▪ Complex oral anatomy – 14; ▪ Inadequate muscle coordination, uncontrolled muscle movements, dysphagia, or excessive gag reflex – 14; and ▪ Lack of demonstration of interest in dentures – 15. ▪ Some individuals had more than one reason listed for not having dentures. <u>Oral Sedation</u> Monitoring and evaluation of use of oral sedation was reviewed. One active record was submitted for an individual who underwent oral sedation. From December 2012 through June 2013, this was the only individual receiving oral sedation for a dental visit. The following summarizes the results of this review: ▪ The submitted record confirmed NPO status or nothing per G-tube at the time of the dental visit. ▪ The submitted record listed the medication administered, the dose, and the route. ▪ The submitted record did not include pre-procedure vital signs in the home. The Dental Department included a statement that the "pre-sedation monitoring form for this individual could not be located." ▪ The submitted record included an examination note/operative IPN/DPN on the date of the visit. ▪ The submitted record did not include pre-procedure vital signs at the Dental Department. ▪ The submitted record did not include intra-procedure vital signs or attempts at vital signs. ▪ The submitted record did not include post-procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in the DPN. ▪ The submitted record did not include a Dental Department follow-up (e.g., phone or visit) the next business day. ▪ The submitted record included a current consent for oral sedation, as well as wristlets, and head and body restraints. ▪ The submitted record included a current HRC review and approval for oral sedation and head and body restraints. ▪ Although consent was obtained for wristlets, head restraints, and body	

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restraints, it could not be determined if these restraints were utilized.
▪ The submitted record did not include a restraint checklist.

A document was submitted entitled “Oral Sedation List, updated 6/15/13.” This listed 10 individuals that had received oral sedation in the past or there were plans to provide oral sedation for a dental visit. However, there was only one individual that received oral sedation in the prior six months.

<u>General Anesthesia/TIVA</u>
The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period from 12/1/12 through 6/17/13. The number of appointments utilizing general anesthesia/TIVA completed per month follow:

<table>
<tr><th>Month</th><th># Completed Visits with General Anesthesia/TIVA</th><th># Scheduled Visits with General Anesthesia/TIVA Not Completed</th><th>Procedure Completed at Area Hospital</th></tr>
<tr><td>December 2012</td><td>10</td><td>6</td><td>Not submitted</td></tr>
<tr><td>January 2013</td><td>11</td><td>1</td><td>Not submitted</td></tr>
<tr><td>February 2013</td><td>13</td><td>2</td><td>2</td></tr>
<tr><td>March 2013</td><td>6</td><td>4</td><td>2</td></tr>
<tr><td>April 2013</td><td>11</td><td>4</td><td>3</td></tr>
<tr><td>May 2013</td><td>11</td><td>3</td><td>1</td></tr>
<tr><td>June 2013</td><td>6</td><td>1</td><td>Not submitted</td></tr>
<tr><td>Total</td><td>68</td><td>21</td><td>8</td></tr>
</table>

It was noted that 60 TIVA appointments were completed at LBSSLC and eight TIVA appointments were completed at the area hospital.

Fifteen individuals did not complete the initial general anesthesia/TIVA appointment. A follow-up appointment was completed under general anesthesia/TIVA for nine of the initial TIVA appointments, which required 10 appointments, as one individual missed one of two appointments before completing a TIVA appointment. Eight individuals missed 11 appointments for TIVA, but remained without a completed appointment. One individual had two TIVA appointments and completed one appointment but not a subsequent appointment.

The active record was submitted for five individuals who had undergone general anesthesia/TIVA from 3/20/13 through 6/12/13. The procedures under general anesthesia/TIVA included one or more aspect of dental care. The list varied in each
</td><td></td></tr>
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		case, and included one or more of the following: prophylactic treatment, exam, restorations, and radiographs. Review of these records revealed the following: ▪ Consent by the guardian/Legally Authorized Representative (LAR) for the dental procedures/anesthesia was current (i.e., defined as completed and dated within 365 days of the procedure) in five of five (100%). ▪ A copy of the HRC review and approval was submitted in five of five (100%). For three of the five, a copy of the completed HRC consent was submitted. For two of five, the HRC approval was listed on a log document. ▪ A pre-operative medical clearance was completed and submitted in zero of five (0%) cases. ▪ A formal pre-operative anesthesia record/clearance by anesthesia was completed and submitted in zero of five (0%). Submitted documentation indicated that a copy of the most recent annual medical exam, current pharmacy profile, and current lab were submitted to the anesthesiologist for review. ▪ An operative note by the dentist was recorded in five of five (100%) cases. ▪ The operative anesthesia record was completed in five of five (100%). ▪ For those with teeth, a periodontal chart/periodontal probe readings were submitted for zero of five (0%). For four of five (80%), there was a determination of periodontal type. ▪ The post anesthesia care Respiration, Energy, Alertness, Circulation, and Temperature (REACT) score, Aldrete Score, or other equivalent discharge scoring assessment was submitted in four of five (80%) of the active records. ▪ A Dental Department follow-up note was submitted for five of five (100%). ▪ Pain medication was prescribed in zero of five cases. It was noted that there were no extractions in these five individuals. ▪ An annual dental assessment was completed while under general anesthesia/TIVA in three of five cases. The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. From a document entitled "Incident of Injury Following TIVA" (dated 5/30/13), over the prior six months, there were no injuries following TIVA administration. <u>Extractions</u> For five individuals that underwent extractions, the dental record was submitted. Three occurred at LBSSLC, and two extractions occurred at the area hospital. The following findings were made: ▪ From the submitted documentation, guardian consent was current in three of five (60%). HRC consent was current in two of five (40%). The Facility did not submit copies of consents when the procedure occurred at the area hospital.	

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		▪ A dental IPN/DPN indicating the need for extractions was documented in one of five (20%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA. ▪ For four of the five cases, IV sedation/general anesthesia was used. ▪ One of five had a local anesthetic. ▪ From one to two teeth were extracted at a visit. This is informational only, ▪ Pain medication following extraction was provided in one of five (20%) cases. ▪ A follow-up dental note the next day was documented in four of five (80%) cases. It was noted that the Clinical Dentist and Hygienist had clinical privileges at the area hospital outpatient surgery department. Three individuals had dental extractions at the area hospital. Two of these extraction cases were part of the data reviewed in this section. <u>Emergency Treatment</u> The Dental Department provided a "Dental Emergency Log" for the months of December 2012 through June 18, 2013. These logs reflected 10 emergencies. Of these 10, 10 (100%) were seen the same day as the emergency contact with the Dental Department. The longest delay appeared to be two hours, and most appeared to have been seen immediately. The "Dental Emergency Log" tracked these emergencies to completion. Nine of 10 were tracked to closure. The one case needing closure occurred 6/10/13, and referral was made to an endodontist and completed prior to July 1, 2013. Examples of emergency treatment were requested for five individuals. Five dental records were submitted. Of these, one was considered not an emergency. Four records were considered examples of emergency dental treatment. The reasons for the emergency were as follows: dental abscess with broken tooth, caries, impacted wisdom tooth with pain, and lesion on mandible. The following findings are made based on this review: ▪ Two of four (50%) records documented the presence or not of pain. ▪ Pain was treated in two of two (100%) cases in which pain was recorded. ▪ Follow-up documentation was submitted for four of four (100%) individuals. ▪ There was documentation of closure of the dental emergency (e.g., either no further visit required or scheduled for procedure) in four of four (100%) cases. For one individual, the appointment had been scheduled, but not completed at the time of submission of information. ▪ The length of time from the identification of the dental emergency in the residence to notification of the Dental Department could not be determined in	

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		any of the four (0%) cases. There was no information submitted indicating the start date and time of the emergency in the residence and the date and time of notification of the Dental Department. ▪ The length of time from the identification of the dental emergency to completion of the Dental Department visit was submitted for one case. The time from identification of the concern in the residence by the PCP to completion of the dental appointment was four hours for that one case in which information was submitted. There was insufficient information submitted to determine that information in the other three cases. To move in the direction of substantial compliance, although as noted in the findings above, other problems existed, the Monitoring Team recommends that the Facility consider the following as areas of focus/priority for the next six months: ▪ Given that the ISP process requires a current annual dental summary within 10 days prior to the ISP, the annual dental summary should not be created based on old information, but the Dental Department should request at the pre-ISP meeting that the IDT prioritize its efforts in ensuring a successful annual dental examination is completed within 30 to 60 days prior to the ISP. When the annual dental summary is based on examinations more than three months in the past, the fact that information may not be current should be highlighted for the IDT. ▪ Dental treatment plans and assessments should comprehensively address an individual's dental status and plan moving forward. ▪ Given the health implications, efforts should be made to overcome the barriers to providing suction tooth brushing to individuals qualified to receive it. ▪ For individuals that brush their own teeth, action should be considered when they have poor oral hygiene, or their oral hygiene rating decrease.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, 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> Policies developed and implemented since the Monitoring Team's last visit included the following: ▪ LBSSLC – Health Services: o "Dental Anesthesiologist," dated 5/1/13; o "General Anesthesia Surgery," dated 5/1/13;	Noncompliance

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	dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	o "Dental Staff," dated 5/1/13; o "Dental Examinations Policy," dated 5/1/13; o "Informed Consent," dated 5/1/13; o "Dental Radiographs," dated 5/1/13; o "Oral Hygiene Tracking," dated 5/1/13; o "Hygiene/Behavior/Tissue Documentation," dated 5/1/13; o "Dental Prophylaxis," dated 5/1/13; o "Dental Recall Policy," dated5/1/13; o "Dental Sedation Plans," dated 5/1/13; o "Medications," dated 5/1/13; o "Guidelines for Change of Diet following Dental Procedures," dated 5/1/13; o "Submission of Dental Summary to IDT," dated 5/1/13; o "ISP Tracking," dated 5/1/13; o "Denture Evaluation," dated 5/1/13; o "Request for a Consultation," dated 5/1/13; o "Community Placement," dated 5/1/13; and o "Preparation, Revision, and Review of Dental Policies and Procedures," dated 5/1/13. Policies in draft form or awaiting approval included the following: ▪ LBSSLC – Health Services: o "General Anesthesia Policy;" o "General Anesthesia Medical Clearance;" o "Post Anesthesia Recovery;" o "General Anesthesiology Personnel;" o "Instructions for Individuals Prior to General Anesthesia Clinic;" o "Pre-operative Sedation prior to General Sedation;" o "Dental Clinic Operations Policy;" o "Dental Services Overview;" o "Dental Infection Control Policy;" o "Dental In-Service Training;" o "Dental Emergencies;" o "Oral Care;" o "Oral Care for Enterally Fed Individuals;" o "Suction Toothbrush;" o "Policy for Crest Spinbrush;" o "Dental Sedation/NPO for an Appointment;" o "Policy for Positioning During Dental Treatment;" o "Chlorhexidine Protocol;"	

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		o "Dental Desensitization;" o "Policy for Occlusal Guard Care;" o "Denture and Partial Care;" o "Attendance Problem Tracking Protocol;" o "Ordering Dental Supplies;" and o "Filter Change for Dental Vacuum System." It was anticipated that these draft policies would be approved in August 2013. The Dental Department is encouraged to review the dental manual to ensure all aspects of the breadth of dental services are included, such as periodontal disease monitoring or the department perspective on periodontal disease monitoring with references, as well as content and scope of specific documents that are included in the manual, such as including the oral cancer screening in the formal annual dental assessment rather than placing this information separately in the active record. Additionally, the role of the Dental Department in dental QA/QI and dental quarterly reports should be included in the roster of policies. If not included in one or more policies, pain management, for emergency visits and post-dental procedure care, as well as documentation of presence of pain, severity of pain, and tracking until resolution of pain. <u>Refusals/Missed Appointments</u> A review of information from a document entitled "LBSSLC Individuals Refusing Dental Services, Reporting dates 12/1/12-6/18/13" indicated that 11 appointments were refused. Five individuals refused these 11 appointments. From a document entitled "LBSSLC All Missed and Refused Dental Appointments, Reporting dates 12/1/12-6/18/13," an additional individual was listed as having refused two dental appointments. Additionally, there were six appointments cancelled or no show due to behaviors. The total number of refused appointments from this second document indicated 19 refused appointments. For the 11 confirmed refused appointments: ▪ Three of the five individuals subsequently completed a dental visit. ▪ Follow-up appointments for two individuals were still pending/remained incomplete (the document date was 6/18/13). ▪ Three individuals refused more than one appointment. Reasons for the scheduled appointments that were refused included: prophylaxis (two appointments), initial exam (one appointment), recall/prophylaxis (three appointments), annual exam (two appointments), TIVA/prophylaxis (one appointment), and restoration (two appointments). The refused appointments occurred from four residences.	

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		From the document entitled "LBSSLC Individuals Refusing Dental Services, Report Dates 12/1/12-6/18/13," the following information was provided: **Month** / **# Refused Appointments** January 2013 — 3 February 2013 — 0 March 2013 — 1 April 2013 — 4 May 2013 — 3 **Total** — **11** ▪ For one individual, the completed appointment occurred from one to 15 days after the refused appointment. ▪ For one individual, the completed appointment occurred from 16 to 30 days after the refused appointment. ▪ For one individual, the completed appointment occurred from 31 to 60 days after the refused appointment. ▪ Two individuals had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document. o The time lapse since the refused appointment date for one individual was 141 days, and for the other individual was 161 days. For the time period from 12/1/12 through 6/18/13, there were 68 missed/no show appointments, which were not categorized as refusals. Reasons for the scheduled appointments that were missed included prophylaxis (14 appointments), exam and treatment under TIVA (17 appointments), annual exam (18 appointments), annual exam and prophylaxis (one appointment), prophylaxis and recall (14 appointments), extractions (zero appointments), other exam (three appointments) and restorations (one appointment). The missed/no show appointments occurred in 13 residences. The major reasons identified for missed appointments included: illness (24 appointments), unknown (12 appointments), not NPO (11 appointments), furlough (four appointments), behaviors (six appointments), dental clinic reasons (three appointments), rights not approved (two appointments), transportation (one appointment), medical clearance (two appointments), and inclement weather (three appointments).	

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Month	# Missed Appointments (Non-refusals)
December 2012	10
January 2013	7
February 2013	4
March 2013	4
April 2013	16
May 2013	22
June 2013	5
Total	**68**

A total of 52 individuals missed 68 appointments. Some individuals might have had more than one appointment for differing indications, of which a follow-up was completed for one and not the other. Fifty-five appointments needed follow-up (the others were not counted, because they were serially missed for the same concern). A follow-up appointment was completed in 29 of 55 cases (53%).

- For eight individuals, the completed appointments occurred from one to 15 days after the missed appointment.
- For nine individuals, the completed appointments occurred from 16 to 30 days after the missed appointment.
- For five individuals, the completed appointment occurred from 31 to 60 days after the missed appointment.
- For five individuals, the completed appointment occurred more than 60 days after the missed appointment. This ranged from 68 days to 174 days.
- For two individuals, the dates submitted as the completed date were entry errors, as the dates were in the future.

The Dental Department submitted information concerning whether the missed/no show appointments were followed by an IDT meeting with an ISPA created to address the no show appointment. The Dental Department indicated that the process of developing and implementing strategies to reduce refused and no show appointments through the IDT process was at an early stage. The Dental Department had no examples of an ISPA in response to a refused or missed appointment. The Dental Department noted that a number of individuals missed TIVA appointments because the individuals were not kept NPO. An ISPA would have been appropriate in some circumstances to empower the IDT to develop steps reinforcing the need for NPO and ensuring it occurred. It was noted that once an individual's preferences were known for the time of day of a dental visit, due to school or work schedules, that some individuals might complete the visit. For these individuals, meeting with the IDT and creating an ISPA to address the need to accommodate the individual's schedule would assist in ensuring the

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		appointment was completed. From a document entitled "LBSSLC Dental Appointments Attendance Sheet, Reporting Dates, December 1, 2012 – June 18, 2012," 389 appointments were made, of which 307 were completed and 81 were missed. This was a 79 percent attendance rate. In January 2013, the Dental Department began an initiative for tracking the reason for missed appointments, including refusals and non-refusal reasons. Each month, the missed appointment summaries were submitted to various departments, including the Unit Directors, Residential Coordinators, RN Case Managers, Assistant Director of Programs, the Director of Residential Services, and the Facility Director. Copies of this correspondence were submitted for report periods of January 2013, February 2013, March 2013, and April 2013. It is recommended that the response from the departments be tabulated and recorded in a database to determine the impact of this approach and the timeliness of response. The Dental Department provided a monthly summary of the reason for missed appointments from the prior month. It is recommended that the document also record the action steps taken by the Dental Department for those that refused/missed (e.g., date of call, name of person/contact, date of IDT with Dental Department representation, QDDP, steps to be taken when an NPO order is written, other steps taken, etc.) Although the summary of reasons for the missed appointments is helpful, identifying there is a problem is only the first step, and the Dental Department might need to take a more active role in order to reduce the refused and missed appointment rate. <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 (data provided from December 1, 2012 through June 18, 2013), there were 307 completed appointments. Zero of 307 (0%) completed appointments utilized mechanical restraints. One of 307 (0.3%) of completed appointments utilized oral sedation. Sixty of 307 (20%) completed appointments utilized general anesthesia/TIVA. There was only one email communication between the Dental Department and the Psychiatry Department concerning need for general anesthesia. One individual underwent three dental visits for prophylactic treatment, but was unable to cooperate. It was not indicated from the note whether oral sedation had been attempted, and if doses had been increased over the three visits, but the Psychiatry Department response indicated that an oral pre-treatment medication would not be sufficient and general	

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		anesthesia was recommended. The Dental Department indicated that individuals with oral sedation prior to the dental visit had been considered appropriate for TIVA/general anesthesia in the hospital setting. The risk/benefit of oral sedation versus TIVA/general anesthesia was not well defined. It appeared that the Dental Department considered TIVA/general anesthesia less of a risk to administer than any level of oral sedation. Rationale of risk/benefit needed to documented and supported by dental references and standards. Rationale of least restrictive approach using oral sedation versus TIVA/general anesthesia also needed documentation. Separately, a list of HRC approved dental and medical restraints was submitted, including the use of sedation, dated 5/30/13. A total of 55 individuals were listed that required dental restraints that had been approved by the HRC. A total of 116 individuals were listed that required dental sedation (i.e., oral sedation and/or TIVA) that had been approved by the HRC. Of these, 107 of 116 (92%) had current consents. For eight individuals, the date of consent was outdated. For one individual, the date of consent was not indicated. <u>Desensitization</u> The Dental Department provided a document entitled "Desensitization Summary," which indicated a change in LBSSLC's methodology for determining need of desensitization plans. According to this document, the Desensitization Committee researched the Settlement Agreement and State Office Policies, and determined that "any service considered non-routine in which sedation is utilized is not considered a restraint and therefore would not require a desensitization plan." From a Dental Scan Call of 4/17/13, further examples were given concerning the procedures that qualify for desensitization versus those that do not require desensitization. These examples included the following statements: "Deep scaling and root plane or full mouth debridement is a painful and non-routine procedure; therefore, no chemical restraint checklist would be required. No desensitization plan either. Routine appointment, such as examination or prophylaxis with oral sedation then would require a chemical restraint checklist." Based on this interpretation, the Dental Department subsequently defined which services were considered non-routine according to current Dental Standards. It was expected that "the number of desensitization plans will drop significantly." The desensitization plans that would no longer apply would be amended to Skill Acquisition Plans with focus on tooth-brushing and flossing skills. These changes were to occur at the subsequent ISP, or through the ISPA process. A document entitled "Desensitization Summary" (undated) was submitted providing	

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		current information concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits. Review indicated the following: ▪ As of 5/24/13, 116 individuals had been identified as requiring desensitization or other plan to reduce the need for restraint. ▪ Of these, 115 (99%) had plans developed. ▪ One individual, that required desensitization or other plan to reduce the need for restraint had not been developed. This was one of 116 (0.9%) individuals documented as requiring desensitization. ▪ According to the Psychology Department, a smaller sample size was reviewed to determine implementation. Fifteen QDDP Monthly Reviews were sampled and 12 of 15 plans (80%) were implemented. The Dental Department had no information about data collection. The Dental Department provided minutes of the Desensitization Committee of 1/11/13 and 4/12/13. The minutes of the 1/11/13 meeting documented there was agreement that the Integrated Program Developers task would be to write the skill acquisition plans, provide the training to staff, train the documentation, and monitor the plans. The Dental Director reviewed the reduced need for oral sedation, as a number of these individuals would benefit from examination and treatment under TIVA/general anesthesia. Although approximately 50 individuals had previously been considered candidates for desensitization, this had been reduced to less than 15 individuals. These 15 individuals will require pre-treatment sedation. As the Dental Department further reviews the decision to reduce the need for desensitization, as well as the increased role of TIVA/general anesthesia, it will be important to provide reference material to substantiate each decision in this process, especially concerning the risk/benefit of TIVA/general anesthesia versus use of oral pre-treatment sedation. An area needing justification would be the use of TIVA/general anesthesia for routine exams and dental prophylaxis without restorations, extractions, and other dental procedures. It appeared that desensitization would focus on self tooth-brushing skills or allowing tooth brushing to be assisted by staff for those 15 individuals, which is an important first step in dental hygiene. However, from the oral hygiene scores across campus, it would appear that more than 15 individuals might be averse to quality tooth-brushing and would benefit from dental desensitization or other oral hygiene improvement plans. Additionally, it would appear those undergoing TIVA/general anesthesia would still need desensitization programs for annual/periodic exams and dental preventive care. Separately, those individuals with noncompliance due to behavioral issues or preferences of the individual would benefit from other initiatives to improve cooperation (e.g., education, reward, scheduling to accommodate the individual's priorities, etc.). The Dental Department should demonstrate an active role in creating	

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		these plans and implementing these plans. The minutes of the April 12, 2013 Desensitization Committee meeting reviewed the different types of sedation as a restraint. The wording of the Settlement Agreement was also reviewed. Assignments were for the Medical Department to define what procedures were routine. The Dental Department was to define the procedures that were considered routine and in which cases the sedation was given for comfort or for behavioral concerns. It was also agreed upon that the current desensitization plans would be amended to become the Skills Acquisition Plan for oral hygiene skills (tooth-brushing and flossing). <u>Quality Assurance/Improvement Initiatives</u> The QA/QI department used the following monitoring tools to review the quality and completeness of dental care: "Texas Health Monitoring Instrument," revised 5/1/12. The QA process included documentation of monthly meetings with the Dental Department. Copies of these "Department and QA Meeting Notes Section Q" were submitted for 2/21/13, 3/22/13, 4/26/13, and 5/22/13. The 2/21/13 was the first meeting between the Dental and the QA Departments, which formalized the discussion. It was documented that the QA Department monitored 100 percent of the dental visits of the prior month, using the dental monitoring tool. The Dental Department did not monitor. Because of this, there was no inter-rater reliability. The QA data indicated a compliance score of 88 percent, but the month was not indicated (this might have been December, because January data was referenced in the 3/22/13 meeting.) This might have been a composite score (which is not useful), and the documentation was not clear. According to the QA Department's review, strengths were the documentation of oral screening and preventive care. Areas of challenge included the completion of annuals every 365 days, placing a completed annual exam form in the active record, the need for treatment plans at the time of the annual exam, the need for justification of extractions, and documentation of oral hygiene instruction at the time of the office visit. The 3/22/13 meeting documented that the QA data revealed a composite compliance score of 91 percent for the month of January 2013. There was no inter-rater reliability due to lack of monitoring by the Dental Department. To accommodate the need to document oral hygiene instruction, the annual examination form was amended to include oral hygiene instructions. The 4/26/13 meeting indicated the sample size of the QA review had been reduced from 100 percent of dental visits in the prior month to a 20 percent sample. The Dental Department continued to not monitor its services. QA provided the only monitoring. The average score was 79 percent, and the month from which the appointments were	

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		sampled was March 2013, leaving February with no monitoring data. The strengths of documentation of oral cancer screening and preventive care continued. An additional challenge was obtaining copies of the anesthesia record from the community hospital, with placement of the documents in the active record. It was noted that the annual exam was revised to include clearance for Reclast administration. The 5/22/13 meeting indicated a composite compliance of 84 percent for a 20 percent random sample of dental appointments from April 2013. As the Dental Department did not complete monitoring, there was no inter-rater reliability. The oral screen score had dropped from 100 percent to 75 percent. There was no documentation of dental preventive care by the direct support professionals. It was anticipated that the new "Treatment Order Record" would improve the documentation of this aspect of dental care. It was also noted that copies of the anesthesia record from the hospital could be obtained and submitted for filing. The 6/28/13 meeting indicated a composite compliance of 84 percent for a 20 percent random sample of dental appointments in May 2013. In the first part of the document, it was reported that the Dental Department scored 100 percent for oral cancer screening documentation and preventive care. It was noted that the annual examination now included oral hygiene instructions. However, the document contradicted itself, as it then stated challenges included the oral cancer screening documentation dropped to 50 percent and preventive care instructions were documented as 75 percent. It was not clear which department generated these monthly reports (i.e., Dental Department or QA Department), but it is recommended that the contents be reviewed for accuracy. The apparent contradictory information in the "Department and QA Meeting Notes - Section Q" of 6/28/13, suggested that these reports were not being reviewed (as the discrepancy would have been addressed), and were not being used as guidance in developing new QI initiatives in the Dental Department. In the past, the QA Department had audited each individual seen in the Dental Clinic for the prior month. This was subsequently dropped to four individuals reviewed for the prior month. For June 2013, this was to be increased to eight per month, which represented three percent of the population per month, or 10 percent per quarter, 20 percent per six months, and 40 percent per year. The sample was to be selected randomly, and the QA Nurse was to complete the audit. The QA Department had created a monitoring tool, which was based on the Dental Department monitoring tool. No inter-rater reliability data had been obtained. The QA and Dental Departments were to meet monthly to discuss of the audit of the prior month and assess for any needed changes.	

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		Internal Dental Department Quality Reviews The Dental Department had not developed any additional internal quality reviews. The Dental Department did not provide monitoring of the department, but relied on the QA Department for data review. The Dental Department did provide a monthly review of the missed and refused appointments. However, there appeared to be no monitoring tool specifically used for systematic measurement on a monthly basis with trend analysis over time. Measurement of steps taken to resolve refusals and missed appointments would provide information as to the time and involvement of the Dental Department in this area (e.g., number of ISPAs attended for dental concerns, number of telephone calls to the residences the day prior to the appointment, or the day of the appointment, number of emails generated for missed appointments, etc.). A review of the dental record by a Dentist would be helpful to determine strengths and challenges using a monitoring tool, with data collection, and ability to analyze dental services over time. As the Dental Department is a small department, consideration should be given to having dentists from other SSLCs review the documents. This could be a sample of documents forwarded to the dentist of the other Facility, with completion of a standardized audit tool with appropriate clinical indicators. A written response would allow initial corrective action steps to be taken. The QA Department noted some weaknesses, which appeared to continue as these were also reflected in the Monitoring Team's review. There was no information concerning how these weaknesses were addressed. When QA notes a weakness from data analysis, it is recommended that an action plan be formally developed and tracked to completion. For instance, the dental plans in the annual dental assessment remained inadequate and a corrective action plan with 30-day follow-up would be an appropriate outcome.	

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 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, or monthly reviews by SLP; alternative and augmentative communication (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), for 20 individuals who had communication deficits, AAC system(s), and/or received direct communication supports, including: Individual #146, Individual #77, Individual #203, Individual #20, Individual #210, Individual #306, Individual #81, Individual #53, Individual #23, Individual #61, Individual #284, Individual #155, Individual #275, Individual #60, Individual #280, Individual #25, Individual #223, Individual #192, Individual #156, and Individual #90; 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 with certificates of completion, since the Monitoring Team's last visit; 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 List of 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; o 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; ○ 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. ▪ **Observations of:** ○ Individuals in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 6/20/13. 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, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT and therapists: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring tool and various Facility-developed audit tools (i.e., communication assessment audit tool) to assess compliance with some of the indicators presented in Monitoring Team's reports. The Director of HT stated that the State Office Section R monitoring tool was not being used. ○ The data presented in the Self-Assessment reflected the completion of activities/audits to assess compliance. These Facility-based audits provided a positive move forward in monitoring compliance with Section R. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. ○ The monitoring tool and audits did include adequate methodologies, such as observations, record review, and staff interview. ○ The Self-Assessment identified the sample sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were chosen for each of the subsections, including sample sizes adequate to consider them representative. ○ The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and the PCM continued to revise the monitoring tool guidelines.

	○ The following staff/positions were responsible for completing the audit tool: The Director of HT, SLPs, and PCM. ○ Adequate inter-rater reliability had not been established between the Director of HT, SLPs and the PCM. ▪ The Facility used some other relevant data sources, including, for example, the HT Department database. ▪ The Facility presented some data in a meaningful/useful way, but more work was needed. Specifically, the Facility's Self-Assessment: ○ Presented findings consistently based on specific, measurable indicators. ○ Did not consistently measure the quality as well as presence of items. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with Section R.1. The Monitoring Team did not find the Facility in substantial compliance with Section R.1. The Facility had made progress with this section. The Facility rated itself in noncompliance with the remaining sections (R.2, R.3, and R.4). These findings were 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 had four SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at LBSSLC. Seven of the seven individuals newly admitted to LBSSLC had communication assessments completed within 30 days. The Facility continued to make significant progress on improving individuals' communication assessments. Although further work was needed to include all of the necessary components, the assessments had begun to provide some important information to teams. ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. It could not be determined if individuals who received direct SL therapy interventions had their plans initiated in a timely manner. Progress notes did not include necessary components. Observations of individuals with AAC systems revealed that some systems were present and/or being used. However, for some individuals the device was not present, broken, and/or not in use. During some observations, staff did not understand how to engage individuals with the systems. Individual-specific staff training and performance check-offs for individuals with AAC devices was an area requiring additional work.

	The Facility did not have a policy and/or procedure for monitoring communication supports. Individuals with AAC systems had been monitored using the Compliance Monitoring form, but not on a consistent basis.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months, including the following ten individuals: Individual #146, Individual #77, Individual #306, Individual #155, Individual #275, Individual #53, Individual #25, Individual #156, Individual #192, and Individual #90. ▪ **Sample R.2:** Four individuals receiving direct speech interventions including: Individual #203, Individual #210, Individual #81, and Individual #284; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits, including: Individual #203, Individual #20, Individual #61, Individual #155, Individual #306, Individual #284, Individual #60 and Individual #223; ▪ **Sample R.4**: Ten individuals with AAC devices including: Individual #146, Individual #203, Individual #210, Individual #81, Individual #23, Individual #284, Individual #275, Individual #280, Individual #192, and Individual #90. 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 addresses 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 system is discussed with regard to Section R.4. **<u>Staffing</u>** The Facility had not developed or implemented a reasonable process to determine what an appropriate caseload would be for SLPs at LBSSLC. A "reasonable process" to determine an adequate number of SLPs would include an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities would include, but not be limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs. The current caseloads for the four SLPs were 33, 58, 60, sand 64 individuals. Two of the SLPs were contracted. The Facility had not initiated an analysis to determine an	Noncompliance

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		adequate caseload for SLPs at LBSSLC. The Facility should complete an assessment to include consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. In addition, an adequate SLP caseload should be related to the Facility's ability to successfully implement the requirements of Sections R.1 through R.4. There were no SLP vacancies. **Qualifications:** ▪ Four of four SLPs (100%) were licensed to practice in the state of Texas. ▪ Four of four SLPs (100%) had evidence of ASHA certification. **Continuing Education** Two of the four SLPs staff (50%) had completed continuing education directly related to communication and transferrable to the population served. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. The continuing education the clinicians attended included the following topics: ▪ Evidence Based Practice for AAC Evaluations (8/1/12 to 8/2/12); ▪ Annual Habilitation Therapies Conference (9/20/12 to 9/21/12); ▪ The Evaluation and Treatment of Dysphagia (10/19/12); ▪ Hard to Swallow: Management of Dysphagia in Older Persons (10/25/12); ▪ Equipment Webinar (2/7/13); ▪ Contoured Seating Using Foam in Place Technology (2/27/13); ▪ Selecting Function-Based Treatments for Socially Maintained Problem Behavior (3/1/13); ▪ Conducting Functional Analysis and Functional Communication Training via Telehealth (3/1/13); ▪ What Constitutes a Behavioral Approach to Autism Treatment? (3/2/13) ▪ Evaluation of Behavioral Persistence (3/2/13); ▪ Applied Behavior Analysis (ABA) Treatment for Autism Spectrum Disorder (ASD): Outcome Research and Public Policy Updates (3/2/13); ▪ Dysphagia/GI Issues in Individuals with Developmental Disabilities (3/6/13); and ▪ Least Restrictive Method of Eating (4/3/13). The two contract SLPs did not obtain CEUs through the Facility. The Facility reported "the two contract SLPs do not obtain CEUs through the Facility. They as well as staff SLPs maintain CEUs per ASHA and Texas State Professional Licensure Guidelines which deems them competent to practice in the State of Texas." If the Facility is going to use contract staff to provide supports required by the Settlement Agreement to the individuals it serves, then the Facility needs to take steps to ensure that the contractors have the	

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		experience and training to allow them to provide supports of adequate quality to this specialized population. This should include ensuring their education and continuing education is relevant to the population, and specifically, that they have "specialized training or experience demonstrating competence in augmentative and alternative communication" as this provision of the Settlement Agreement requires. **Facility Policy** The Facility submitted the following policy: ▪ LBSSLC - IDT – Program Development: Speech/Communication Assessment Process. This policy referenced the State Supported Living Center Policy Communication Services #016, effective 10/7/09. The State and Facility policy only addressed some, but not all of the components necessary for a comprehensive SLP policy. Although, the Facility policy had a monitoring section, it was not sufficiently comprehensive. The components contained in the State and Facility policy are underlined below. When finalized, the Facility policy should address the components that are not underlined: ▪ Roles and responsibilities of the SLPs (meeting attendance, staff training etc.); ▪ Outline of the assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission); ▪ 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 ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as problem resolution. The essential components of a monitoring policy are addressed with regard to Section R.4. In summary, the Facility had four SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at LBSSLC. Two of the SLPs	

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		had completed continuing education. Continuing education documentation was not submitted for the two contract SLPs. The Facility did not have a SLP policy that fully reflected current practices and expectations. The HT Department should ensure revised policies include the elements listed within this section. The Facility remained out of compliance with this subsection.	
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.	**Communication Assessments Provided** Seven of seven individuals newly admitted since the last review (i.e., Individual #121, Individual #46, Individual #64, Individual #47, Individual #71, Individual #81, and Individual #83) (100%) received a communication screening or assessment within 30 days of admission. **Communication Assessment** Based on review of the individuals in Sample R.1, the comprehensiveness of the communication assessments were as follows: ▪ Nine of 10 individuals' SL assessments (90%) (i.e., Individual #146, Individual #77, Individual #306, Individual #155, Individual #275, Individual #53, Individual #156, Individual #192, and Individual #90) were signed and dated by the clinician upon completion of the written report; ▪ Ten of 10 individuals' SL assessments (100%) were dated as completed at least 10 working days prior to the annual ISP; ▪ Nine of 10 individuals' SL assessments (90%) (i.e., Individual #146, Individual #77, Individual #306, Individual #275, Individual #53, Individual #25, Individual #156, Individual #192, and Individual #90) included diagnoses and relevance of impact on communication; ▪ Ten of 10 individuals' SL assessments (100%) included individual preferences, strengths, and needs. Preferences listed were derived from the Preferences and Strengths Inventory (or other relevant document) developed by the individual's team, as well as information obtained from staff interviews; ▪ Ten of 10 individuals' SL assessments (100%) included medical history and relevance to communication. The medical history refers to medical conditions that would impact the provision of SLP communication supports and services; ▪ Ten of 10 individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Ten of 10 individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Four of 10 individuals' SL assessments (40%) (i.e., Individual #306, Individual #53, Individual #25, and Individual #156) 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 10 individuals' SL assessments (80%) (i.e., Individual #146, Individual	Noncompliance

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		#77, Individual #306, Individual #275, Individual #53, Individual #25, Individual #156, and Individual #192) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ Three of 10 individuals' SL assessments (30%) (i.e., Individual #306, Individual #53, and Individual #156) 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; ▪ Ten of 10 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. The SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Ten of 10 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. The SLP assessment provided an analysis of the individual's current communication deficits with suggestions for direct interventions and/or skill acquisition programs; ▪ None of 10 individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings. The SLP assessment should present clinical data to support the effectiveness of the individual's current supports. This clinical data should include the results of individual-specific compliance and effectiveness monitoring; ▪ Nine of the 10 individuals' SL assessments (90%) (i.e., Individual #77, Individual #90, Individual #146, Individual #306, Individual #275, Individual #53, Individual #25, Individual #156, and Individual #192) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC; ▪ Four of 10 individuals' SL assessments (40%) (i.e., Individual #77, Individual #275, Individual #146, and Individual #25) offered a comparative analysis of health and functional status from the previous year. The SLP assessment should provide an overview of an individual's health status over the past year. The therapist should discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status; ▪ None of 10 individuals' SL assessments (0%) gave a comparative analysis of current communication function with previous assessments. The SLP assessment should provide an overview of the past assessment results with the current assessment data for communication function. The assessment analysis should discuss if the individual's communication performance has remained the same, has improved, and/or has regressed; ▪ Ten of 10 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Ten of 10 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff;	

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		▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule; ▪ One of the 10 individuals' SL assessments (10%) (i.e., Individual #146) supplied a monitoring schedule. The SLP assessment should discuss monitoring results from the previous year and recommend the implementation of a monitoring schedule for the upcoming year. The therapist should describe the monitoring form(s) to be utilized. For the remaining individuals, the Communication Equipment section stated: "direct support professional staff is responsible for monitoring this equipment daily for use and wear." However, these individuals' assessments did not present compliance and/or effectiveness monitoring results, or the monitoring schedule to be implemented for the upcoming year for compliance and effectiveness; ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition. As required by State Office, for these individuals, therapists included their opinions about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needed were missing in the community; and ▪ Ten of the 10 individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessments provided suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. The SLPs continued to make significant progress in including necessary elements in comprehensive SLP/communication assessments. However, additional work was needed to ensure comprehensive SLP assessments included all the necessary assessment elements. **<u>SLP and Psychology Collaboration:</u>** Based on review of individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Eight of eight individuals' communication assessments and PBSPs reviewed (100%) addressed the connection between the PBSP and the recommendations	

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		contained in the communication assessment. ▪ Eight of eight individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Facility Behavior Support Committee meeting attendance sheets from 11/15/12 to 5/13/13, participation by a SLP was noted in 16 of the 28 meetings (57%). Individuals' communication assessments continued to improve. However, the Facility is encouraged to focus on the remaining components that were not yet included or consistently included in the assessments. The Facility remained out of compliance with this subsection.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Integration of Communication in the ISP** Based on review of the ISPs for ten individuals in Sample R.4, the following was noted: ▪ Seven of the 10 individuals' SLPs (70%) (i.e., Individual #203, Individual #210, Individual #81, Individual #23, Individual #284, Individual #280, and Individual #192) attended the annual ISP meeting. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, team should provide clear justification if they decide that therapists involved the individuals' care and treatment do not need to attend. For the individuals in the sample, the ISP Preparation Meeting documentation indicated that: o Four of the ten individuals did not have a Pre-ISP Preparation meeting (i.e., Individual #81, Individual #23, Individual #284, and Individual #192). o The ISP Preparation Meeting documentation for two of the remaining six individuals' (i.e., Individual #203 and Individual #210) indicated the attendance of a SLP was required. A SLP attended these individuals' annual ISP meetings. o Documentation for three of the remaining six indicated that one HT representative was required to attend the ISP meeting. The rationale provided to only require a representative from HT was not adequate for these individuals (i.e., Individual #275, Individual #280 and Individual #90). However, a SLP did attend the meeting for Individual #280. Individual #275 and Individual #90 had prescribed AAC devices. The expertise of the SLP would have been helpful in assisting IDT members to understand how to imbed these individuals' AAC devices in daily activities and skill acquisition programs. o Individual #146 had a Pre-ISP meeting, but team members required to attend the annual ISP meeting were not identified.	Noncompliance

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		▪ Seven of 10 ISPs reviewed (70%) (i.e., Individual #146, Individual #210, Individual #81, Individual #23, Individual #284, Individual #275, and Individual #280) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. These ISPs contained information on how staff could improve communication with the individual. The types of AAC and/or communication supports (including, but not limited to the Communication Dictionary and strategies for staff use) were identified. ▪ Five of 10 ISPs reviewed (50%) (i.e., Individual #146, Individual #210, Individual #81, Individual #284, and Individual #275) included how communication interventions were to be integrated into the individual's daily routine. ISPs should contain information on how communication strategies can be integrated throughout the day and throughout the other selected goals. Information should be consistent with the communication assessment and provide detailed descriptions to ensure staff consistency. ▪ Seven of 10 ISPs reviewed (70%) (i.e., Individual #146, Individual #203, Individual #81, Individual #23, Individual #275, Individual #280, and Individual #192) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of 10 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate. **<u>Development and Implementation of Functional Individual-Specific Assistive Communication Systems</u>** Observations were conducted in the homes and/or day programs of nine individuals (i.e., Individual #53, Individual #81, Individual #284, Individual #306, Individual #156, Individual #77, Individual #275, Individual #289, and Individual #192) with AAC systems in Sample R.4. Findings included the following: ▪ Four of nine observations (44%) (i.e., Individual #53, Individual #81, Individual #284, and Individual #77) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for three of nine individuals (33%) (i.e., Individual #53, Individual #81, and Individual #284) were noted to be in use in each observed setting. ▪ AAC systems for eight of nine individuals (89%) were portable. Staff could not	

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		locate Individual #192's AAC system, so this could not be evaluated. ▪ AAC systems for nine of the nine individuals (100%) were functional. ▪ For nine of nine individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices** The Facility indicated the intent of all common area devices was to promote communication skills and encourage incidental learning in the context of daily living activities. The Facility provided a communication equipment list that identified shared AAC devices that included the location and type of device. The Monitoring Team observed the presence of general-use AAC devices during observations of individuals in their residences and workshops. These devices included staff instructions. However, the Monitoring Team did not observe staff and/or individuals utilizing these generic devices. **Direct Communication Interventions** Seven individuals were receiving direct speech interventions. Sample R.2 included four of these individuals (i.e., Individual #203, Individual #210, Individual #81, and Individual #284). Review of these individuals' records found the following: ▪ None of four individuals' direct intervention plans (0%) was implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The Monitoring Team's review of plan documentation did not provide a development date. Consequently, it could not be determined if these individuals' direct intervention plans were implemented within 30 days of their creation. ▪ For none of four individuals' records (0%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. ▪ For none of four individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of four individuals (0%) information was present regarding whether the individual showed progress with the stated goal on a monthly basis. ▪ For none of four individuals (0%) a description was found of the benefit of the device and/or goal to the individual. The therapist should have reported on a monthly basis through the provision of clinical data how the goal was supporting communication for the individual in his/her daily activities. ▪ For none of four individuals (0%), a report was found regarding the consistency of implementation. ▪ For none of four individuals (0%) recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Based on the therapist's monthly data, if a lack of progress is noted, team review would be necessary to determine if the plan is	

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		being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. **Competency-Based Training and Performance Check-offs:** Four SLPs and a Trainer were approved communication trainers for communication foundational training. Competency-based training and performance check-offs for communication are addressed with regard to Section O.5 for new employees and veteran staff. **Individual-Specific Competency-Based Training** One of the ten individuals' staff (i.e., Individual #81) (10%) in Sample R.4 had received individual-specific training. However, the training documentation presented was not adequate to ascertain if all required staff had completed competency-based training and performance check-offs for individuals' AAC devices. More specifically: ▪ Only one of Individual #81's staff had signed an in-service training sheet. There was no completed competency performance check-offs related to her daily communication schedule and/or yes/no board. No information was presented that identified the total number of staff that required training and the total number of staff that had successfully completed individual-specific competency-based training and performance check-offs. To meet the standard of competency-based training, the performance check-offs should include a demonstration component for individual-specific communication programs. In addition, the Facility should present data that identifies the total number of staff that would require individual-specific training for an individual's AAC systems (N) and the total number of staff that have successfully completed performance check-offs. In summary, ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. Observations of individuals with AAC systems revealed that some systems were present, but for other individuals the systems were not present, not functioning and/or not being used. It could not be determined if individuals who received direct SL therapy intervention had their plans initiated in a timely manner. Progress notes did not include necessary components. Individual-specific training and performance check-offs had only been developed and implemented for one individual with an AAC system in the sample. The Facility remained out of compliance with this section.	

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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 Facility's policy and/or procedures did not include the following elements related to monitoring: ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels; ▪ The process for identification, training, and validation for monitors; ▪ The process of establishing inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). **Monitoring of Implementation of Communication Supports** The Compliance Monitoring form for communication devices was initiated on 2/27/13. The form tracked staff compliance with 10 indicators, including staff communication with individuals before/after activities; PNMP and AAC device was present and/or easily located and current; skill acquisition plan was being followed; device/equipment was present, working and utilized; staff was able to demonstrate how to support the individual in using shared devices; staff could locate monitoring sheets; staff explained risks associated with not implementing the program; staff had been trained on program; staff entered data correctly; and staff identified who to contact if there was a problem. Four SLPs and seven PNMP Coordinators were responsible for monitoring. Monthly schedules using the Communication Compliance Monitoring form were presented from November 2012 to May 2013 with the exception of January 2013. For January 2013, the Facility reported that no communication monitoring was completed due to limited SLPs on staff. AAC Individual Equipment Monitoring and Communication Compliance Monitoring forms were reviewed for individuals in Sample R.4 and the following was found: ▪ The Monitoring Team requested documentation of AAC equipment monitoring for the past six months. Five of the ten individuals with AAC systems (i.e., Individual #90, Individual #210, Individual #192, Individual #280, and Individual #284) (50%) had been monitored using the AAC Individual Equipment Monitoring Form. This form monitored if the equipment was present, clean, in use, and staff demonstration. However, none of these	Noncompliance

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		individuals' equipment was monitored on a monthly basis over the past six months. These five individuals' AAC devices were only monitored in January 2013 using the AAC equipment monitoring form not the Communication Monitoring Form. Furthermore, the forms were not completed since sections were left blank (i.e., in-use and staff demonstrated). ▪ Three of the ten individuals' staff (i.e., Individual #81, Individual #210, and Individual #275) (30%) had been monitored using the Compliance Monitoring form for communication. Additional information on the status of expanding the scope for compliance monitoring is discussed with regard to Section O.6. The Facility policies/procedures should incorporate the elements presented within this section. In addition, individuals with AAC systems had not been monitored on a consistent basis using the Compliance Monitoring form. The Facility remained out of compliance with this subsection.	

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)/Preferences and Strengths Inventory (PSI), Individual Support Plans, Skill Acquisition Plans (SAPs), and SAP raw data and Monthly Reviews for the last three months, as available, for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; o For Section S.1, Dental or Medical Desensitization Skill Acquisition Plans for: Individual #281, Individual #68, Individual #120, Individual #164, Individual #190, and Individual #47; o For Section S.2, Individual Support Plans, Preferences and Strengths Inventory, and Functional Skills Assessments, as available, for: Individual #197, Individual #73, Individual #127, Individual #220 Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284; o For Section S.2, Vocational Assessments, as provided, for: Individual #300, Individual #126, Individual #321, Individual #173, Individual #137, Individual #181, Individual #320, Individual #79, Individual #185, and Individual #217; and o For Section S.3, Skill Acquisition Plans (SAPs), as available, for: Individual #197, Individual #73, Individual #127, Individual #220, Individual #36, Individual #46, Individual #34, Individual #306, Individual #202, Individual #242, Individual #183, Individual #70, Individual #77, and Individual #284. ▪ **Interviews with**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 7/8/13 and 7/9/13; o Tracey Snow-Murphy, Director of Residential Services, Rodshadi Moore, Active Treatment Supervisor, and Marty Jones, Integrated Program Developer, on 7/9/13 and 7/10/13; o Jim Forbes, Director of Behavioral Services, Carolyn Milton, Assistant Director of Behavioral Services, and Bob Robbins, QA Program Compliance Monitor, on 7/10/13; o Tracey Snow Murphy, Director of Residential Services, and Marilyn Foster, QA Program Compliance Monitor, on 7/10/13; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 7/10/13; o Sandi Kennedy, QDDP Coordinator, Section F meeting, on 7/10/13; o Mary Ortiz, Director of Competency Training and Development, and Irma Curry, Senior

	Instructor, on 7/11/13; and o Tracey Snow-Murphy, Director of Residential Services as well as Marty Jones, Integrated Program Developer, Jennifer Sageser, Integrated Program Developer, Sylvia Rios, Integrated Program Developer, and Reagan Criswell, Integrated Program Developer on 7/11/13. ▪ **Observations Conducted**: o Observation of PBSP competency-based training at Violet (523), on 7/9/13; o Observation at Behavior Support Committee (BSC) Peer Review Meeting, on 7/11/13; o Observation of PBSP Competency Integrity Check at Oak (518), on 7/11/13; o Observation of PBSP Competency Integrity Check at Tulip (526), on 7/11/13; o Desensitization Committee Meeting, on 7/11/12; o Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the afternoon and/or evening hours at the following sites: ▪ Birch (514), on 7/8/13; ▪ Fir (516), on 7/8/13; ▪ Oak (518), on 7/9/13 and 7/11/13; ▪ Willow (520), on 7/9/13; ▪ Rose (525), on 7/10/13; ▪ Iris (527), on 7/10/13 and 7/11/13; ▪ Zinnia (528), on 7/10/13; ▪ Aspen (513), on 7/11/13; ▪ Canna (521), on 7/11/13; ▪ Violet (523), on 7/11/13; and ▪ Tulip (526), on 7/11/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 6/20/13. 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. Based on verbal reports, this rubric was utilized by QA/QI staff in conjunction with the Director of Residential Services and other Active Treatment staff on a monthly basis (i.e., four samples per month). This was consistent with previous reports. In addition, compliance scores (across items) as well as inter-rater reliability estimates were generated per month. Lastly, regular meetings appeared to be held to review the ongoing use of this rubric and to promote improved accuracy and reliability

	over time. ▪ Used other relevant data sources and/or key indicators/outcome measures. o The current Self-Assessment contained several additional tools including, review of active records, SAP quality checks, active treatment engagement monitoring forms, vocational assessment quality tool, PSI and FSA Quality Assessment Tool, as well as several databases (i.e., tracking spreadsheets for vocational assessments, SAPs, PSIs, FSAs, engagement, program observations, training rosters and competency scores, and community outings). ▪ The Facility consistently presented findings based on specific, measurable indicators. ▪ However, the Facility did not consistently measure the quality as well as presence of items. ▪ The Facility did not rate itself as being in substantial compliance with any subsections of Section S. This was consistent with the Monitoring Team's current findings.
	Summary of Monitor's Assessment: Efforts to support the development of quality Skill Acquisition Programs (SAPs) was noted. This included the addition of new staff, a new SAP format, a new SAP development curriculum, and the utilization of a new quality assessment tool. However, significant concerns remained regarding the quality of SAPs, including ongoing data collection, monitoring, and adequate review. That is, although it appeared that the Facility was improving the resources and processes necessary to support the development of quality programming, the Facility still appeared to be in the midst of transition regarding the effective development, implementation, and monitoring of SAPs. Indeed, concerns regarding the quality and adequacy of monitoring were noted across all sampled SAPs, including dental and medical desensitization plans. Consequently, it continued to be unlikely that the majority of skill acquisition programs were currently promoting growth, development, and independence for individuals served at LBSSLC. Estimates of engagement during the onsite visit were consistent with previously estimated levels. This finding was inconsistent with estimates the Facility reported. However, it should be noted that QA and active treatment staff continued to utilize different tools when conducting engagement probes. Substantial efforts aimed at training staff in the areas of active treatment, including engagement and SAPs, was evident. However, inadequacies in training materials as well as in efforts aimed at ensuring implementation integrity, including inter-rater agreement, were noted. In addition, efforts directed at supporting day and vocational programming were noted, but these supports had not yet evidenced measureable progress in providing on- or off-campus employment opportunities. Progress was observed in the area of conducting annual assessments targeting individuals' preferences, strengths, skills, and needs, including in the areas of living, working, and engaging in leisure activities. However, concerns regarding the adequacy of completed PSI, FSAs, and vocational assessments remained. Lastly, most of the individuals sampled appeared to have one or more SAPs that identified the community as a potential setting to facilitate generalization. However, concerns regarding adequate and sufficient opportunities for skill acquisition in community settings, including the lack of a systematic method for monitoring individual performance over time, continued to be observed. Similarly, opportunities for

	community integration continued to remain inadequate for many of the individuals residing in the Facility.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Although efforts to support the development of quality Skill Acquisition Programs was noted, significant concerns remained regarding their quality and the adequacy of ongoing SAP monitoring and review. Efforts directed at supporting day and vocational programming were noted, but these supports had not yet evidenced measureable progress in providing on- or off-campus employment opportunities. Currently, a random sample of completed SAPs from 14 individuals who had an Individual Support Plan meeting over the past six months were selected for review. Overall, a total of 57 SAPs provided for these individuals were briefly reviewed and it was found that approximately four (range of one to seven) SAPs were developed, on average, for each individual sampled. In addition, it appeared that 42 (74%) of the SAPs were completed using the new SAP format. In an effort to more closely examine the quality of these current skill plans, one SAP was selected randomly and reviewed for each individual. These SAPs are identified below. In addition to the examination of each SAP identified below, the available Functional Skills Assessments, Preferences and Strengths Inventory, Individual Support Plans, Monthly Reviews, and SAP data sheets, for the last three months, as provided, were reviewed as well and were the basis of the subsequent findings. The following SAPs were included in the sample: ▪ The SAP for Individual #197 targeting using a calendar; ▪ The SAP for Individual #73 targeting communication; ▪ The SAP for Individual #127 targeting restocking work material; ▪ The SAP for Individual #220 targeting on-task behavior at work; ▪ The SAP for Individual #36 targeting tooth brushing; ▪ The SAP for Individual #46 targeting shaving; ▪ The SAP for Individual #34 targeting attendance at work; ▪ The SAP for Individual #306 targeting replacement behavior; ▪ The SAP for Individual #202 targeting hand washing; ▪ The SAP for Individual #242 targeting hair brushing; ▪ The SAP for Individual #183 targeting dental desensitization; ▪ The SAP for Individual #70 targeting signing initials; ▪ The SAP for Individual #77 targeting purchasing; and ▪ The SAP for Individual #284 targeting pacing at meals. The selected SAPs (as noted above) were examined to determine if each was based on the individuals' needs as identified in the ISP or available assessments including the PSI, FSA, or other assessment. All of the SAPs included a rationale section with many referencing assessments as well as recommendations of staff from various disciplines or	Noncompliance

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		settings, including direct support professionals. It is important to remember that discussions at ISP meetings with various professionals or direct support staff does not equate to identification of needs through the completion of formal assessment(s). Currently, of the 14 SAPs reviewed, it appeared that 11 (79%) identified one or more assessments as the basis of the targeted need. Of these 11, two (18%) appeared consistent with the findings of those assessments (i.e., the FSAs for Individual #197 and Individual #36). The exceptions included three SAPs that identified assessments (habilitation and nursing) that were unavailable for review (i.e., Individual #73, Individual #202, and Individual #183) and six SAPs that listed the FSA as the basis of the SAP when, based on the Monitoring Team's review, it appeared that the assessment did not conspicuously recommend or specify the identified need. More specifically, the FSAs for several individuals did not appear to conspicuously identify the need as indicated within the SAP (e.g., Individual #127, Individual #220, and Individual #284). And, although individually scored items appeared to reflect a need, the summary or recommendations of the SFA did not highlight the need(s) targeted by the SAP. Indeed, in some cases, it appeared that information in the ISP or FSA contradicted or opposed the identification of the need targeted by the SAP. More specifically, it appeared that discussion by the IDT as reflected in the ISP actually supported the discontinuation of the AAC device for Individual #73, and scored items on the FSA appeared to suggest independence in the area targeted by the SAP for Individual #284. In some cases, the written descriptions on FSAs could not be comprehended (e.g., Individual #242). Overall, it continued to be a challenge to determine if the needs targeted by the majority of SAPs reviewed were based on recommendations within completed assessments. Lastly, although determining the basis of the identified needs targeted by SAPs was difficult, 12 (86%) of the SAPs sampled were identified in the ISP. The exceptions were Individual #36 (not conspicuously found) and Individual #73 (information did not appear to support the SAP). Overall, the links between SAPs and identified assessments were not conspicuously supported by responses to items and/or summaries found within identified assessments. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that SAPs be conspicuously based on completed assessments. Upon review of the 14 SAPs it was noted that 10 (71%) were completed using the most current SAP format. In an effort to provide a comprehensive review of the most current SAPs, these 10 SAPs were reviewed and the following was observed: ▪ One (10%) had an adequate behavioral objective. This included Individual #242 who had a behavior objective that included a goal behavior, clear specifications of the conditions (or context) within which the behavior was to occur, and the criteria or standards for determining when the objective had been accomplished. It should be noted that most SAPs, given the inadequacy of the task analysis, did	

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		not provide sufficient operational definitions of the goal behavior, and did not include specification of the conditions within which the behavior was to occur (within the objective); ▪ Zero (0%) had an adequate task analysis. It should be noted that all of the SAPs appeared to operationally define the targeted skill 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. ▪ Seven (70%) had an adequate description of necessary materials. Those SAPs with inadequate or unclear information about materials included Individual #220, Individual #183, and Individual #70; ▪ Ten (100%) had an adequate description of the setting/environment; ▪ Eight (80%) had sufficient opportunities for learning to occur (i.e., adequate schedule of implementation). SAPs with insufficient or unclear information about implementation included Individual #127 and Individual #183; ▪ Four (40%) included adequate discriminative stimuli. These included SAPs for Individual #183, Individual #242, Individual 34, and Individual #284; ▪ Ten (100%) conspicuously identified the type of chaining (forward, backward, or total task) utilized in the SAP. However, concerns were noted as described below; ▪ Two (20%) identified the instructional strategy (e.g., least-to-most). These included the SAPs for Individual #197 and Individual #202; ▪ Zero (0%) provided adequate descriptions/definitions of the types of prompts within the listed prompt hierarchy; ▪ Although 10 (100%) identified an initial prompt level, only three (30%) indicated a criterion of when to change to a less (or a more) intrusive prompt level. This included those for Individual #197, Individual #202, and Individual #242; ▪ Of the four SAPs that utilized forward chaining (Individual #202, Individual #183, Individual #70, and Individual #220), three (75%) had instructions on when to increase or decrease prompt levels. The exception was Individual #220; ▪ Ten (100%) described specific consequences for correct responding. However, concerns were noted as described below; ▪ Ten (100%) described specific consequence for incorrect responding. However, concerns were noted as described below; ▪ Ten (100%) identified the use of reinforcement following correct responding. However, only two (20%) utilized individualized reinforcers other than social praise; ▪ Zero (0%) identified adequate plans for generalization and maintenance; and ▪ Ten (100%) contained data collection instructions. However, only six (60%) appeared to prescribe sufficient data collection. Exceptions included those SAPs	

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		with prescribed data collected two or less times per week (i.e., Individual #202, Individual #127, Individual #183, and Individual #70). Overall, the reviewed SAPs continued to demonstrate the need for improvement. Examples of these concerns are noted below: ▪ Identified discriminative stimuli appeared to include only verbal responses from staff and, at times, included additional, seemingly unnecessary, verbal responses. The Facility should consider avoiding the use of additional verbal cues or consider using other types of cues that might be more naturalistic, foster more independence, and/or lessen the likelihood of prompt dependence, especially to verbal prompts; ▪ For most of the SAPs sampled, behavioral objectives appeared inadequate. That is, many provided vague references to a target behavior (e.g., "… independently work…," "… sit still…," and "… attend work…") that were not adequately defined. In the past, many of these behaviors were defined through the task analysis. However, given the inadequacy of the task analyses, the target response(s) was often unclear. In addition, behavioral objectives typically identify conditions or contexts under which the skill would be performed, but these were not typically included; ▪ Task analysis steps should specify the required response of the individual not the staff and include sufficient detail to assist with teaching a complex skill. Writers should remember that the purpose of a task analysis is to break a complex skill or a series of behavior into smaller, teachable units. In several cases, there was only one step identified within the task analysis (i.e., Individual #34 and Individual #242) and additional seemingly unnecessary staff responses were prescribed (e.g., Individual #36 and Individual #197). At times, steps within the task analysis contained vague references to behavior (e.g., Individual #220). Overall, the noted concerns reflected questions regarding the adequacy of the task analysis as well as whether or not using a task analysis was appropriate given the target of some of the SAPs. ▪ In some cases, steps of the task analysis did not appear to differ (Individual #70) or appeared more likely to shape increasing dimensions of behavior (e.g., duration) than an effort to chain together a sequence of discrete responses aimed at teaching a complex skill (e.g., Individual #202, Individual #220, and Individual #183); ▪ The prompting strategy (e.g., most-to-least or least-to-most) was only conspicuous in only two of the SAPs sampled (e.g., Individual #197 and Individual #202); ▪ Descriptions used to define the type of prompts within the prompting hierarchy (e.g., gestural, verbal, etc.) were often inconsistent, inaccurate, and, at times, confusing. That is, it appeared that these were described as both "prompts" and	

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		"cues" (e.g., Individual #36 and Individual #197), provided narrow definitions of what might be included (e.g., Individual #284), and appeared inappropriately linked to the discriminative stimulus (e.g., Individual #242 and Individual #127). The Facility should consider standardizing how the prompts within the typical hierarchy are defined; ▪ Repeated use of the same prompt level, following incorrect responding, was found in several sampled SAPs (e.g., Individual #197, Individual #36, Individual #202, and Individual #242). It was unclear why a typical prompting sequence (e.g., most-to-least or least-to-most) would not be followed following an incorrect response(s); ▪ Although strategies promoting the utilization of differential reinforcement appeared much improved, the use of robust, individualized reinforcement (other than social praise) following correct responding was only found in two (20%) of the SAPs sampled; ▪ Unlike previously reviewed SAPs, current strategies regarding error correction appeared to include an attempt to avoid inadvertent reinforcement. However, subsequent detail with regard to error correction procedures appeared lacking. That is, detailed instructions describing adequate staff responding following an incorrect trial needs to be included within the SAP. This should include guidance on how to prompt correct responding relative to the identified instructional strategy; ▪ Criteria of when to change to a new step was only conspicuously identified in three of SAPs sampled (Individual #197, Individual #202, and Individual #183); ▪ More description related to generalization and maintenance should be included in the SAP. This should include specific plans to conduct generalization trails before and after the skill is acquired under variable stimulus conditions. In addition, specific plans to conduct maintenance trials using the SAP of acquired skills also should be prescribed as well. It should be noted that previous SAPs appeared to included more comprehensive and helpful descriptions related to generalization and maintenance; and, ▪ None included a criterion for review if limited or no progress was noted. Overall, concerns remained with regard to development of quality SAPs as noted above. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that SAPs contain critical elements as highlighted above. In an effort to examine the nature of data collection with regard to skill acquisition programming, raw data sheets for each SAP as identified above, including the last three months of data (as provided), was reviewed. It should be noted that review of data from this sample was challenging, because many of the selected individuals had ISP meetings in March (n=5) and April (n=6). Consequently, SAPs for these individuals might not have	

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		started until April or May. In addition, it should be noted that June data sheets appeared unavailable at the time of the on-site document request, because only data from June 2013 was provided for one (7%) individual sampled (Individual #70). This was of concern, given that the visit was in July 2013. Nonetheless, review of the provided raw data indicated: ▪ For individuals with ISPs in January (n=1), adequately completed data sheets for all three months (March, April, and May) was provided for zero (0%) of the selected SAPs. That is, only one data sheet was provided for Individual #306; ▪ For individuals with ISPs in February (n=2), completed data sheets for all three months (March, April, and May) was provided for zero (0%) of the selected SAPs. Indeed, only one data sheet was provided for Individual #46 and two data sheets for Individual #77; ▪ For individuals with ISPs in March (n=5), completed data sheets for two months (April and May) was provided for two (40%) of the selected SAPs (Individual #197 and Individual #284). The exceptions included Individual #220 (only May data provided), Individual #34 (only April data provided), and Individual #183 (no data provided); ▪ For individuals with ISPs in April (n=6), completed data sheets for May was provided for five (83%) of the selected SAPs (Individual #73, Individual #127, Individual #202, Individual #242, and Individual #70). The exceptions included Individual #36 (May data sheet was blank). It should be noted that identifying when sampled SAPs were actually implemented, in an effort to determine when data should have been collected, was challenging, because implementation dates were only recorded on 10 (71%) of the SAPs sampled. The exceptions were the SAPs for Individual #73, Individual #46, Individual #306, and Individual #77. Given this ambiguity, findings (as noted above) still reflected significant amounts of missing data. Closer examination of the available data revealed additional concerns about the adequacy of the data as well. More specifically, it was evident that, even when data was collected, it was not collected as prescribed for the majority of individuals. For example, although total task chaining was prescribed, data was only collected on single steps for Individual #284 and Individual #77. Similar concerns were noted for Individual #220, Individual #70 and Individual #202, where SAPs prescribed forward chaining and the data sheet, alternatively, prescribed total task chaining. In addition, data sheets differed across months for some SAPs (Individual #197 and Individual #202), and, in some cases, contained task analyses that were different from those found within SAPs (Individual #73, Individual #183, Individual #242, and Individual #202). For some individuals, multiple data sheets for each month were completed (i.e., it was unclear why extra data was collected) and, when comparing findings on the same dates, different data was	

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		recorded (e.g., Individual #73). Lastly, problems were noted with regard to the adequate review of ongoing performance as reflected by the data sheets as well. More specifically, only 11 (79%) of selected individuals had all the sampled SAPs signed by reviewers on a monthly basis and only three (27%) of the eleven evidenced review of the monthly data sheets within one month of their completion. These included Individual #127, Individual #34, and Individual #284. Indeed, some individuals' data sheets were reviewed many months after the data was actually recorded (e.g., Individual #77 and Individual #242). And, it was noted that in some cases, reviewers appeared to misinterpret progress (i.e., comparing progress across April and May data sheets for Individual #284), or did not record the review dates on one or more of the SAPs data sheets reviewed (e.g., Individual #70, Individual #73, Individual #183, Individual #202, and Individual #220). Overall, based on the review of the sampled raw data sheets, significant concerns remained with regard to the adequacy of data collection and ongoing monitoring of skill acquisition programming. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that raw SAP data is collected accurately and completely. The Monthly Review was a new format that was developed and introduced since the Monitoring Team's last visit to provide progress monitoring (i.e., action plan review) on each individual's goal and desired outcomes across the various sections of the ISP, including living options, relationships, employment, leisure, and independence as well as review any changes with regard to the PSI or other sources of data (e.g., observation notes, integrated progress note). Each month, the QDDP was expected to specifically examine progress on each formal training objective and provide a summary. Consequently, provided Monthly Reviews, from the last three months (as available), were examined for each of the 14 individuals sampled. That is, the Monitoring Team examined the correspondence between the Monthly Review and the actual monthly data sheets as well as timeliness of their completion. For the 14 individuals sampled, the following was found: ▪ Monthly notes, for the months of March, April and/or May 2013 were available for 12 (86%) of those sampled. Exceptions included Individual #220 and Individual #36; ▪ Of the 12 available monthly notes, reference(s) to the selected SAP was found for 10 (83%) of the individuals sampled, with the exceptions of Individual #46 and Individual #306; ▪ Of the 12 available monthly notes, a description of current status was found within five (71%) of the seven in-place SAPs in April 2013 as well as within nine (75%) of the 12 in-place SAPs in May 2013. However, the information provided in several descriptions was vague and did not include data (i.e., Individual #197, Individual #73, and Individual #34), or a review/summary was not provided	

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		due to the inadequacy or lack of raw data (i.e., Individual #77 and Individual #183). In addition, in some cases, when data was described in the monthly note, it did not appear consistent with the actual raw data sheet (i.e., Individual #202 and Individual #284); ▪ Graphic display of data appeared in two (16%) of the monthly notes reviewed. These included the notes for Individual #242 and Individual #70. However, it could not be determined if the data relative to the sampled SAPs was included in the graphic displays as the titles on the graphs were vague and the graphs themselves (including the data) was un-interpretable; ▪ Of the 12 available monthly notes, it appeared that six (50%) were completed in a timely fashion (i.e., signed and dated within 30 days of the month targeted). These included Individual #127, Individual #34, Individual #306, Individual #202, Individual #183, and Individual 70; and ▪ Overall, of the 12 monthly notes, only one (8%) of the monthly notes sampled appeared to adequately describe and review monthly progress in a timely fashion (i.e., Individual #127). Overall, 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. This sample included a total of six SAPs, including three targeting dental desensitization (i.e., Individual #281, Individual #68, and Individual #120) as well as three targeting medical desensitization (i.e., Individual #164, Individual #190, and Individual #47). Of the six desensitization SAPs reviewed, the following was observed: ▪ Zero (0%) had adequate behavioral objectives. Although all of the sampled SAPs had objectives that specified specific criteria and a deadline, none provided an adequate operational definition of the goal behavior or specified a condition (or context) in which the behavior was to occur (i.e., as part of the objective). In addition, the behavior in the objective did not necessarily match the behavior identified within the task analysis (e.g., Individual #281); ▪ Zero (0%) appeared to have an adequate task analysis. Previously, SAPs appeared to operationally define the targeted skill using the current task analysis. Currently, the inadequacy of reviewed task analysis did not support adequate definition of the goal behavior; ▪ Six (100%) had an adequate description of necessary materials; ▪ Five (83%) had an adequate description of the setting/environment. The exception was Individual #190 where the setting described in the "environment" section did not match the setting described in the objective or task analysis; ▪ Five (83%) had sufficient opportunities for learning to occur (i.e., adequate	

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		schedule of implementation). The exception was Individual #190 (i.e., schedule of implementation could not be identified); ▪ Four (67%) described adequate relevant discriminative stimuli. The exceptions included those with additional verbal cues and required responses that could unnecessarily lead to additional chained responses (i.e., Individual #120 and Individual #190); ▪ Six (100%) conspicuously identified the type of chaining (i.e., forward chaining) utilized in the SAP; ▪ Zero (0%) appeared to provide adequate descriptions for all of the prompts within the listed prompt hierarchy; ▪ Although six (100%) identified an initial prompt level, only one (17%) identified the instructional strategy (e.g., least-to-most) and zero (0%) identified the criteria necessary to increase or fade the prompt level; ▪ Six (100%) identified a success criteria necessary to change steps (i.e., to move to the next step on the task analysis); ▪ Six (100%) described specific consequences for correct responding. However, concerns were noted as described below; ▪ Six 100%) described specific consequence for incorrect responding. However, concerns were noted as described below; ▪ Six (100%) identified the use of reinforcement following correct responding. However, only two (33%) utilized individualized reinforcers other than social praise; ▪ Zero (0%) identified adequate plans for generalization and maintenance; ▪ Six (100%) contained special instructions as well as description related to data collection. However, only two (33%) appeared to prescribe a sufficient frequency for data collection (Individual #281 and Individual #120); and ▪ Although six (100%) described monitoring procedures, zero (0%) included an objective criterion for review if limited or no progress was noted. Overall, the findings for dental and medical desensitization plans were consistent with the findings for other SAPs as reported above. Given the consistency within these findings, it continued to be unlikely that the majority of skill acquisition programs, including dental and medical desensitization programs, were currently promoting growth, development, and independence across most individuals served at LBSSLC. Verbal reports from the Director of Behavioral Services indicated that psychologists and behavior analysts would remain the primary authors of SAPs targeting replacement behaviors, counseling supports and skills, and those targeting more complex skills related to dental or medical desensitization. In addition, verbal reports indicated an effort to continue to promote closer collaboration between behavioral services staff and the SAP developers through regular meetings and, potentially in the future, more comprehensive review of sampled SAPs across disciplines. To move in the direction of	

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		substantial compliance, the Monitoring Team recommends that the Facility ensure that medical and dental desensitization SAPs included critical elements as noted above. As noted in previous Monitoring Team reports, skill acquisition program observation probes were completed to estimate staff knowledge and skills in implementing SAPs. In addition, as noted in previous Monitoring Team reports, the format of this rubric had been frequently revised over time. Previous reviews noted continued concerns with the adequacy of this rubric as well as with the specificity of the summary data provided as evidence of its utilization. Currently, during the Monitoring Team's recent visit, verbal reports again suggested slight revision of the program observation rubric. Review of the provided Skill Acquisition Program Observation revealed a format that examined both demonstrative indicators (i.e., based on implementation of the SAP) as well as knowledge (i.e., based on verbal report of information on the SAP) of staff. The scoring of these items was the basis of the integrity score for that SAP during the integrity probe session. In addition, the format included two questions that examined the adequacy of collected data based on informant record review. Although this appeared to be helpful and informative, it was unclear to the Monitoring Team where this data was displayed and/or monitored and reviewed over time. As previously noted, the rubric would be improved by more closely aligning current items with critical elements found within the SAP. For example, items that are not currently identified, but should be considered for inclusion, included: 1) determining if staff can adequately identify the behavior (skill) being taught; 2) identifying/using any individualized reinforcer(s); 3) identifying/using the current prompt level being targeted; 4) identifying/using the identified instructional strategy; 5) identifying/using the correct prompting hierarchy (least-to-most, most-to-least); 6) identifying/using any specific instructions; or 7) identifying/demonstrating when to change steps or change prompt level across trials. The Facility should consider these recommendations, integrate other improvements within the rubric, and conduct inter-rater reliability checks as increasing numbers of probes are completed. Currently, provided summary documentation evidenced that only a small number of observation probes were conducted in January and February 2013 (i.e., "Skill Acquisition Program Observation Monthly Report" for January and February 2013). It should be noted that the Monitoring Team did not directly observe staff conducting SAP integrity (program observation) probes while on site. This was in response to feedback provided by the Director of Residential Services who reported that the newly hired SAP developers were not yet experienced and fully competent in conducting integrity probes. Consequently, the Facility had yet to demonstrate evidence that SAPs were consistently implemented with a high degree of integrity. This finding is based on the lack of any summary data that demonstrated adequate implementation of integrity probes. More specifically, data from February and March 2013 was provided that evidenced the completion of SAP program observation probes in some homes across four	

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		raters. However, probes were not conducted within several of the programs each month. Consequently, the Facility should ensure that SAP implementation occurs with a high degree of fidelity across all programs. In addition, efforts should be aimed at demonstrating that integrity probes are completed with a high degree of accuracy and reliability. As presented in the Monitoring Team's previous report, it was strongly recommended the Facility train all SAP developers as well as active treatment staff in the completion of these probes, including ensuring a high degree of inter-rater reliability across raters. Data on these reliability checks should be collected, summarized, and analyzed over time to ensure that raters continue to demonstrate competency in completing skill acquisition integrity checks. In addition, data on the number of probes completed within each program each month should be tracked and estimates adequately displayed. Currently, it remains unclear how the single engagement estimate was generated based on the description that four probes per month per home were completed. Since the Monitoring Team's last visit, four staff members were hired as Integrated Program Developers and given the primary responsibility of writing SAPs. At the time of the recent onsite visit, these professionals were engaged in writing the majority of SAPs. This included developing new SAPs or revising previous SAPs for individuals concurrent with their ISP meeting. Psychologists and Behavior Analysts, however, continued to share some of the responsibility for writing SAPs, as they were still required to write programs targeting replacement behaviors, including counseling SAPs, and more complex dental or medical desensitization programs. Integrated Program Developers were also primarily responsible for attending Pre-ISP and annual ISP meetings as well as training key (more experienced) staff members (e.g., Home Team Leaders, Residential Coordinators) who would then assist with training direct support professionals. In addition, they were charged with tracking the development of SAPs (using a new spreadsheet), as well as monitoring that competent staff members implemented SAPs correctly. As part of the recent progress, the curriculum ("Skill Acquisition Plan - Instructions for SAP Development, revised 5/22/13) for developing SAPs was revised. This curriculum provided an overview of the ISP process as well as provided specific guidance in developing adequate SAPs. Feedback on revisions to the curriculum was provided on site by the Monitoring Team and included the following: ▪ SAPs should included the date they are written and implemented; ▪ SAPs should include objectives that include: 1) a goal behavior; 2) clear specifications of the conditions or context within which the behavior is to occur; and 3) the criteria or standards for determining when the objective has been accomplished. It should be noted that the SAP should sufficiently define the goal behavior and ensure that it is objective/measureable;	

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		▪ Descriptions of staff responses following correct and incorrect responding need to be more robust. That is, staff will need direction on how to identify a correct and incorrect response with regard to the type of instructional strategy (e.g., forward, backward, total task) as well as relative to the specific step of the task analysis as well as the prescribed prompt level. Additional direction/instruction regarding when to fade prompting as well as increase prompting when necessary, depending on individual responding, appeared needed as well. Lastly, a delay (e.g., five seconds) often should be prescribed in SAPs to inform staff how long to wait for a response before a trial (lack of response) is recorded as incorrect; ▪ More comprehensive direction/instruction on the provision of reinforcement following correct responding should be provided, especially clarification relative to the type of instructional strategy utilized; ▪ More comprehensive and accurate descriptions of total task, backward chaining, and forward chaining need to be included. The information provided included inaccurate descriptions of the instructional strategies as well as how reinforcement is delivered relative to the specific strategy used. It would be important when describing these different strategies to highlight implications for differences in data collection, and the importance of identifying the identified teaching step as well as prescribed prompting level; ▪ More direction/instruction regarding generalization was also necessary. Descriptions should include specific instructions on how SAPs will be taught under varied stimulus conditions. It should be noted that generalization applies to more than just settings or times, as highlighted within the current curriculum. That is, specific strategies to teach a skill and reinforce its occurrence under varied stimulus conditions (e.g., people, materials, similar discriminative stimuli, etc.) should be promoted and described within the curriculum and prescribed within SAPs; and ▪ More direction/instruction regarding maintenance was also necessary. Descriptions should include specific instructions on how skills taught through SAPs will be maintained over time. This should include the occasional implementation of mastered SAPs to examine whether or not the individual can demonstrate the skill independently. Specific plans to support the regular examination of acquired skills to ensure that they are being maintained are necessary. Additional progress was noted in the ongoing revision of the tool used ("SAPs Quality Assessment Tool Instruction Sheet," 5/21/13) to ensure the quality of SAPs. Feedback from the Monitoring Team on the content of this form was provided during the onsite visit. This included a critical review of many of the items on the form as well as how many of the items were scored. For example, as discussed during the onsite visit, the	

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		scoring indicators (i.e., "0," "1," "2") on the form need to accurately reflect possible responses specific to the actual item listed. It is recommended that this form be revised to mirror revised SAPs, based on revisions within the SAP development curriculum as well as the Monitoring Team's feedback in the current as well as previous reports. Based on verbal report as well as provided documentation, it appeared that the Integrated Program Developers utilized the SAP Quality Assessment Tool in an effort to estimate the quality of the initial SAPs developed using the newly revised format. Provided data indicated that a limited number (N=3) of SAPs were reviewed in both March and April 2013. Although the scores appeared to reflect quality (i.e., scores exceeded 86% and 80% across three SAPs scored by each reviewer in March and April 2013, respectively), concerns were noted with regard to the adequacy in the number of quality tools completed; the adequacy of items on the rubric, including missing items; how the rubric was scored; and the lack of inter-rater reliability estimates across raters. The Monitoring Team recognized that the Facility's recent revision in the SAP curriculum as well as the Monitoring Team's suggested revisions as offered during the onsite visit as well within this report, would take time to translate into practice. It is expected that corresponding changes in actual SAPs will be increasingly evident over time. Consequently, the Monitoring Team looks forward to examining related progress during the next monitoring visit. Overall, although substantial effort had been observed in improving the resources and processes necessary in the development of quality programming, the Facility still appeared to be in the midst of transition regarding the effective development, implementation, and monitoring of SAPs. Indeed, verbal reports from the Active Treatment Supervisor indicated that training for new employees would continue to target the previous SAP format, because many individuals continued to have programming utilizing the older format. 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	

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Location	*Engaged*	*Staff-to-individual ratio*
Birch	1:1	1:1
	1:1	1:1
Willow	0:1	0:1
	1:2	0:2
Oak	1:2	0:2
	1:4	1:4
Zinnia	3:4	1:4
	2:2	1:2
Iris	1:2	1:2
Rose	0:1	0:1
	1:1	2:1
Canna	0:2	1:2
	1:1	1:1
Violet	3:5	2:5
Tulip	2:3	1:3
	4:6	2:6
Violet	2:3	1:3
Iris	0:2	0:2
Aspen	2:4	0:4
	1:1	1:1
	2:6	1:6

According to collected data, during brief residential visits overall engagement was 56%. This reflected minimal change in the estimated level of engagement compared to the previously estimated level (55%) evidenced at the Monitoring Team's last visit. An engagement level of at least 75% would be a typical target for a facility like LBSSLC. Consistent with observations during the Monitoring Team's previous visits, the staff-to-individual ratios observed in some settings were concerning. Consistent with findings from previous Monitoring Team visits, observations from the current visit suggested inadequate staff-to-individual 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, adequate engagement data had not been provided. More recently, in the Monitoring Team's last report, seemingly adequate levels of engagement had been reported. For example, previously reviewed summary

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		data of approximately 230 monitoring observations reflected average monthly estimates of 88%, 90%, 91%, and 90% engagement scores for April, May, June, and July 2012, respectively. Summary data presented at that time also evidenced similar engagement estimates reported by QA staff. That is, total engagement estimates reported by QA staff (i.e., collapsed across residence, work and day programs) ranged from 89 to 97% over the past six months. However, it was noted that QA and active treatment staff were utilizing different rubrics at that time. Current verbal reports from the Director of Residential Services as well as the Active Treatment Supervisor indicated that this inconsistency had not yet been resolved. Currently, provided documentation indicated that a revised rubric, entitled the "Engagement Monitoring Form" revised 3/13/12, was utilized to estimate the competency of the staff being monitored to promote active engagement (Part I) as well as to estimate individual engagement (Part II). Based on the format, it appeared that items on Part I were completed based on verbal report as well as direct observation and items on Part II were based only on direct observation. Items assessing engagement, including whether or not daily schedules were followed, were recently revised. This also included a table to record data following a prescribed one-minute observation period were the number of individuals engaged (compared to the total number of individuals) within an area was measured. The revised form allowed raters to record percentage of the total number of individuals engaged during the observation period. Currently, provided documentation evidenced overall percentage of active engagement estimates between September 2012 and June 2013. More specifically, estimates for the months between September 2012 and June 2013 were 90%, 92%, 86%, 0%, 62%, 63%, 63%, 0%, 71%, and 0%, respectively. It was unclear to the Monitoring Team why data was not collected in December 2012, and April and June 2013. In addition, it was unclear how these estimates were generated. That is, it is unclear how these percentages were calculated (e.g., if they were averages). In addition, summary information did not evidence any data specific to number of probes conducted per month, which programs were targeted, and/or when (shifts) the data was collected. However, the Facility provided data from May 2013 that indicated that poor engagement estimates were related to staff not following the schedule. This was a bit surprising to the Monitoring Team, because substantial efforts were reported in March and April (as noted below) to facilitate active engagement through the use of the new activity schedules. During future visits, the Monitoring Team will examine whether or not engagement rates improve over time as the use of these schedules, hopefully, becomes more integrated into typical daily routines. Since the Monitoring Team's last visit, it appeared that the Active Treatment Supervisor had provided a substantial amount of training to direct support professionals and other residential and program staff targeting the areas of active treatment, including	

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		engagement, and skill acquisition programming. More specifically, staff training attendance rosters reflected at least nine eight-hour trainings, held between 1/17/13 and 5/24/13, primarily for direct support professionals and QDDPs (approximate N=75), targeting "The Principles of Active Treatment Services." This training appeared to be a comprehensive review of active treatment, including engagement, individual and group scheduling (in-home activities and community-based trips), medication, and skill acquisition programming. Since the Monitoring Team's last visit, it appeared that the Active Treatment Supervisor had provided a substantial amount of refresher training to direct support professionals and other residential and program staff targeting SAPs. That is, staff training attendance rosters also revealed at least 25 two-hour trainings, held between 2/28/13 and 5/24/13, for a wide range of residential, vocational, and program staff (approximately N=367), targeting the most recently revised "Skill Acquisition Programs 2013 Edition" training curriculum. Additional evidence, in the form of summary listings of trained staff (Skill Acquisition Program March 2013), similarly indicated that approximately 356 staff, including direct support and active treatment staff as well as vocational and supported employment staff completed refresher training (as noted above) targeting the SAPs. Additional summary documentation ("Active Employee Course Participation Report" dated 1/1/12 to 6/26/13) similarly evidenced the training of Facility staff (N=310) throughout March and April 2013 on the "Skill Acquisition Programs 2013 Edition." Summary documentation provided indicated that staff completing the refresher training on SAPs, using the Skill Acquisition Programs 2013 Edition, completed competency testing at the end of each training session. Based on this data, it appeared that only 59% of the staff passed following the first testing session. Data indicated that 98% of trainees, however, scored at competency (90%) or higher following the initial and, as necessary, subsequent testing session. It should be noted that the nature of this re-training as well as of the subsequent testing session was unclear to the Monitoring Team. That is, it was unknown if those who failed the first competency test were required to attend an additional training session and whether or not the same test was used. Although a competency test ("Competency Testing for SAP Trainers," dated 2/13/13) was provided for review, it was unclear to the Monitoring Team if this was the test utilized following the refresher trainings or if this test was primarily used with SAP Trainers (i.e., Residence Coordinators, Home Team Leaders, Assistant Home Team Leaders), as indicated. Although summary documentation reflected efforts to ensure competency of staff following refresher trainings on SAPs, similar efforts to ensure competence of staff following recent trainings utilizing the revised "The Principles of Active Treatment Services" was not provided. In addition, although a staff training attendance roster	

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		evidenced an additional training for the Residential Coordinators on "SAP training," it was unclear what curriculum was utilized and whether or not competency of trainees was assessed following the training. Provided documentation did include samples of competency testing of direct support professionals conducted by Integrated Program Developers. However, there was no summary documentation to reflect the comprehensive or systematic use of these tests with direct support professionals across all Facility programs. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that current training materials include the most accurate and current information regarding skill acquisition programming. That is, many of the concerns noted above (i.e., with regard to the quality of the SAPs and ongoing monitoring) were identified as problems within the current training materials. Consequently, the Facility is encouraged to review Monitoring Team's previous and current feedback regarding ways to improve the quality of SAP development, training, and ongoing monitoring. Verbal report and provided documentation evidenced efforts at improving active treatment through the use of out-of-home and in-home group activity schedules (including specific procedures), daily objective schedules, and individualized data cards describing relevant personal information including precautions and special considerations, likes/dislikes, SAP goals, and identified specific preferred activities. External consultants facilitated these efforts, and staff training rosters (dated 3/19/13), including signatures of administrative, professional, and clinical staff, as well as posted materials a member of the Monitoring Team observed during onsite residential visits provided evidence of these activities. However, evidence that these efforts had produced noted changes in active engagement was not evident. That is, as reported above, reported summary data continued to reflect inadequate engagement rates, with provided evidence suggesting that activity schedules were not being correctly followed (i.e., Engagement Monitoring for May 2013). As reported in the Monitoring Team's previous report, the number of individuals in vocational programs and the number of individuals in on-campus, but off-home day programs had increased. In addition, three individuals were currently engaged in off-campus supported employment. At that time, however, no changes were evident in the number of individuals served in the on-campus workshops or in the on-campus Client Worker program, and minimal change was reported in the number of individuals involved in the Enterprise program or placed within off-campus competitive employment positions. Overall, as reported in the Monitoring Team's previous report, a decreasing trend was evident in the number of individuals supported in off-campus Enclave settings, but improvements were noted in involving individuals in day programs	

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		outside of their homes, as well as in supporting more individuals in supported employment positions. Currently, summary data the Facility provided (i.e., POI referenced monthly data tracking spreadsheet, including months of September 2011 through June 2013) was reviewed and the findings are reported below: ▪ When examining data regarding the number of individuals in on-campus vocational programs, it appeared that the number increased substantially from July 2012 to February 2013 (i.e., a range of 128 to 132 individuals per month) compared to previously reported rates in September 2011 to June 2012 (i.e., a range of 106 to 109 individuals per month). Recently, a significant reduction was reported in March to June 2013 (91 individuals per month). Overall, the entire data set revealed a decreasing trend over time; ▪ When examining data regarding the number of individuals in on-campus workshops, it appeared that the number remained stable from September 2011 to February 2012 (a range of 84 to 87 individuals per month). However, a significant reduction was reported in March to June 2013 (to 77 individuals per month). Overall, with this recent stable decrease, the entire data set revealed a dramatic decreasing trend over time; ▪ When examining data regarding the number of individuals in off-campus supported employment, it appeared that the number increased substantially from September 2012 to February 2013 (a range of seven to eight individuals per month) compared to previously reported rates from September 2011 to August 2012 (a range of zero to three individuals per month). Currently, the number of individuals in supported employment has slightly decreased since February 2013 (from eight to six individuals per month). Overall, the entire data set revealed an increasing trend over time followed by, in the last six months, a decreasing trend; ▪ When examining data regarding the number of individuals in the Client Worker program, it appeared that the number increased substantially from December 2011 to February 2013 (to 25 individuals per month) compared to previously reported range in September to November 2011 (of 11 individuals per month). Recently, a significant reduction was reported in March to April 2013 (to seven individuals per month) with a slight increase in June 2013 (to nine individuals per month). Overall, the entire data set revealed a decreasing trend over time; ▪ When examining data regarding the number of individuals in off-campus enclave work, it appeared that the number continually decreased over time. Rates of individuals decreased from December 2011 to August 2012 (i.e., a range of two to five per month) compared to previously reported rates in September to November 2011 (nine per month). More recently, data reflected zero (0) individuals in enclave work settings each month in September 2012 to June	

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		2013. Overall, the entire data set revealed a dramatic decreasing trend (until reaching zero) over time; ▪ When examining data regarding the number of individuals in the enterprise program, the number remained relatively consistent from September 2011 to February 2013 (i.e., a range of 16 to 18 per month). Recently, a significant reduction was reported in March to June 2013 (zero individuals per month). Overall, given this significant and stable decrease, the entire data set revealed an decreasing trend (until reaching zero) over time; ▪ When examining data regarding the number of individuals in off-campus competitive employment, it appeared that the number decreased over time. Individuals employed per month decreased to zero from September 2012 to June 2013 compared to previously reported rates in September 2011 to August 2012 (a range of one to two individuals per month); ▪ When examining data regarding the number of individuals working part-time on-campus and/or off-campus, it appeared that the number initially decreased and has remained stable over time. That is, rates decreased from December 2011 to March 2013 (to seven individuals per month) from previously reported rates in September to November 2011 (of 22 individuals per month). Overall, since December 2011, the number of individuals in part-time work either on-campus and/or off-campus had remained unchanged; ▪ When examining data regarding the number of individuals in on-campus day programs (but out of their homes), it appeared that the number increased substantially from July 2012 to February 2013 (i.e., a range of 211 to 216 per month) compared to previously reported rates in September 2011 to June 2012 (i.e., a range of 117 to 119 per month). Recently, a significant reduction was reported in March to June 2013 (a range of 121 to 123 individuals per month). Currently, rates had remained substantially lower since March 2013 compared to the significantly higher rates observed in late 2012 and early 2013. Overall, the above data reflected mixed results. That is, the majority of data reflected either a recent decline or no progress. More specifically, although improvement was noted in previous years, recent data (i.e., since March 2013) reflected significant decreases in individuals served in the vocational, workshop, client worker, and enterprise settings. Total number of individuals attending day programs off their homes also decreased since March 2013. Data reflected no substantial change in the small number of individuals in part-time on-campus and off-campus work as well as no change in individuals hired to work in competitive employment settings. Unfortunately, increases in supportive employment positions had been slowly diminishing over the last six months as well. It should be noted that it was challenging for the Monitoring Team to evaluate the data	

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		with regard to trends over time, because the Facility did not graphically display the above data allowing efficient monitoring and/or interpretation of performance over time. This lack of effective data display continued to be challenge to ongoing monitoring and a consistent inadequacy the Monitoring Team noted. In addition, the data presented above was inconsistent with data provided from another source (i.e., data displayed in a table included within the Vocational Accomplishment Summary Packet). More specifically, data reflecting the number of people working on campus (i.e., client worker program) and the number of people in community enterprise program were inconsistent (i.e., substantially different) with data found in the monthly data tracking spreadsheet (as described above). Lastly, the Monitoring Team noted that this data likely underestimated the work and progress the Facility had made. More specifically, as the number of individuals transitioning into community-based residential programs grows, the more likely this attrition might negatively skew the data. That is, some of these individuals previously held successful on-campus or off-campus day or vocational positions, and, as a result of their departure, the data no longer reflected that position (i.e., even though they might continue to successfully hold onto that position). Consequently, the Facility is encouraged to consider ways to account for attrition in their data sets in order to make more meaningful and representative comparisons over time. Currently, according to documentation provided and verbal reports from the Director of Vocational and Day Programs, since the Monitoring Team's last visit, ongoing efforts to improve opportunities for on-campus and community-based employment continued. Efforts included the continuation of two committees, the Attendance Committee and Community Outreach Committee. As described in the Monitoring Team's last report, the attendance committee worked to improve attendance at both vocational and day programs by tracking attendance and working with IDTs to correct identified barriers and improve attendance. Current verbal reports and provided documentation indicated that this committee was still active in facilitating better attendance by individuals the Facility served to on-campus programming. Documentation evidenced that, between January and June 2013, the assessment committee held a monthly meeting in five (83%) of the six months during this time period. That is, no meeting minutes were provided for April 2013. In addition, provided documentation indicated that data on attendance at day and vocational programs was being collected. Based on provided summary data as well as a provided monthly example (November 2012), it appeared that this data monitoring system allowed review of attendance rates by program, program area, and residence. This data collection and review provided data from September 2012 through June 2013, and indicated that attendance at day programs (range from 42 to 76% per month) reflected a slight decreasing trend over time and attendance at vocational programs (range from 63 to 92% per month) reflected a slight increasing trend over time. Consequently, it appeared that efforts to promote attendance had been more effective for vocational programs. Although this was a positive outcome, increases in	

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		attendance might have been more helpful within day programs, because individuals in these programs evidenced a lower average attendance (67% per month) compared to individuals in vocational programs (average attendance of 86% per month). As previously noted, the community outreach committee was developed to improve the number and variety of employment opportunities both on- and off-campus. To this end, this committee worked to build and maintain relationships with community-based businesses as well as provide education to individuals about different vocational opportunities through exploration tours, situational assessments, and other training and supports by job coaches. Indeed, one of the goals of this committee was to conduct quarterly business meetings to facilitate potential partnerships by improving awareness of the needs of community businesses and potential services and employment base offered by the Facility. Indeed, verbal reports and documentation evidenced a community business leaders luncheon (on February 21, 2013) that appeared to be successful in raising awareness. Documentation was not provided that evidenced a business meeting during the second quarter. This committee also initiated systems to monitor the development and maintenance of business contacts as well as completed vocational exploration trips. Documentation also evidenced that between January and June 2013, the community outreach committee held a monthly meeting in six (100%) of the six months during that time period. In addition, provided documentation indicated that data on vocational related community trips, including vocational explorations and trips related to the enterprise program and new employment, was being collected. Provided data from September 2012 through June 2013 indicated that, on average, approximately 54 vocational trips were completed each month (range of 31 to 62 trips per month) and reflected an increasing trend over time. However, during the same time period, data indicated that, on average, approximately three vocational exploration trips were completed each month (range of zero to eight trips per month) and reflected a decreasing trend over time. In addition, during the same time period, data indicated that on average, approximately six trips related to the enterprise program were completed each month (range of three to 11 trips per month) and reflected a decreasing trend over time. Lastly, only three trips related to new employment were completed during the same time period. In addition to the two committees described above, a third committee, the Assessment Committee, was also developed to track the completion of vocational assessments as well as to ensure their quality and timeliness. The committee also was charged with ensuring the competency of the assessors, identify vocational visions, and identify and facilitate the completion of vocational explorations. Documentation evidenced that, between January and June 2013, the assessment committee held a monthly meeting in six (100%) of the six months during that time period. In addition, data from September 2012 through May 2013 indicated that 170 vocational assessments were completed during	

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		this time period. Data also indicated that 93% of the vocational assessments were completed on time and 71% of the vocational explorations were completed as expected. However, it was unclear how the committee identified which individual(s) would benefit from vocational explorations. That is, not everyone with a vocational assessment was selected for a vocational exploration. According to the data, 31 (18%) individuals with completed vocational assessments were identified for explorations and, in the end, only 22 (71%) explorations were completed as identified within this nine-month period. This represented the completion of explorations for 13% of those individuals with completed vocational assessments. In addition, a system was developed to assess and monitor the quality of assessments through the completion of a vocational quality tool by assessors. Also, an Employment Grid/Employment Visions tracking system was recently initiated to monitor efforts at supporting individuals to obtain their identified employment vision. These processes as well as further review of the quality of vocational assessments are described below with regard to Section S.2 of the Settlement Agreement. Lastly, other efforts at improving opportunities with vocational and day programs involved the support of an assigned psychologist who worked collaboratively with vocational committees, expansion of opportunities for individuals at Hearts and Hands (including a new setting at Estacado Industries Workshop and more variety in products) as well as at the Diner (e.g., breakfast cart, extended hours). In addition, the responsibility of completing vocational assessments recently had been assigned to two full-time assessors. Lastly, work opportunities appeared to be facilitated though an increasing diversity of on-campus work (e.g., car washes) as well as access to a new shredding truck and confidential shredding policies. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to strive to identify community-based opportunities, including vendors and others within the systems the Facility utilizes, to trial and ultimately place individuals in supported or competitive employment positions. Successful community-based employment will continue to be an increasing need to ensure more individuals are placed in the most integrated work setting.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	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 reviewed assessments remained. As described in the Monitoring Team's previous report, the Facility had begun to use the Preferences and Skills Inventory to facilitate the identification of individual goals and preferences, as well as the necessary subsequent assessments. In addition, the Functional Skills Assessment had been implemented to facilitate the examination of a	Noncompliance

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		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, PSI, and FSA, as provided, were examined. Of the 14 individuals reviewed, documentation evidenced completion of PSIs for 14 (100%) individuals within the last 12 months. However, it should be noted that 13 (93%) were completed prior to the ISP meeting. The exception was Individual #197, for whom a PSI was completed four months after the date of the ISP. Of the 14 individuals sampled, zero (0%) appeared to be adequately completed. Overall, the PSIs for 11 (79%), 10 (71%) and two (14%) individuals appeared to evidence adequately completed Section I, Section II, and Section III, respectively. For Section I, the PSIs for three individuals did not describe how the individual communicated (as the basis for the responses to the items) and/or did not adequately complete all of the items (Individual #284, Individual #73, and Individual #202). For Section II, the PSIs for four individuals either did not complete a summary section (Individual #127 and Individual #306) or the listed preferences and/or strengths did not appear consistent with those identified in Section I (Individual #284 and Individual #202). Also, only two individuals' PSIs appeared to adequately integrate identified strengths and preferences when the teams identified goals (Individual #197 and individual #220). However, one of these two teams completed the PSI months after the ISP meeting (Individual #197). In addition, only the PSI for two individuals contained summaries for preferences and strengths for each section as prescribed (Individual #73 and Individual #197). Lastly, only one (7%) PSI suggested a target goal for SAP (Individual #70). Overall, none of the 14 individuals sampled had PSIs that were adequately completed and available prior to the ISP. The Monitoring Team offers the following examples to the Facility as feedback regarding common inadequacies found within the sampled PSIs: ▪ The PSI for Individual #284 was inadequate based on: 1) many items were not completed in Section I (page 3 under employment); 2) the fact that most of the preferences identified in the Summary were not identified or described in relevant items in the assessment (i.e., there was not a clear connection between the descriptions offered in response to items in Section I and the conclusions offered in the summary of Section II); and 3) the preferences and strengths provided in Section III were vague and not conspicuously linked to descriptions offered in response to items in Section I (e.g., there were multiple references to strong preferences for watching TV and going into the community to shop and eat, but these were not found in Section I or Section II).	

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		▪ Items in Section I of the PSI for Individual #46 clearly indicated that the individual wanted a new job, but did not know what options were available. This was not described or mentioned in the analysis (Section III). Other goals within Section II were vague and appeared unrelated to findings of the assessment. For example, under leisure time, the goal indicated "[Individual] will receive support from his staff in the next 12 months." This did not appear to be an adequate goal as it did not target skill acquisition for the individual and did not appear to be related to any of the strengths or preferences identified in the assessment. ▪ Items in Section I of the PSI for Individual #34 indicated a desire to consider changes in current living options and potential settings. However, the recommended goal in Section III indicated that "[Individual] would benefit from remaining at her current residence." This did not appear to be an adequate goal and it did not appear consistent with responses the individual provided related questions in Section I. Overall, many of the sampled PSIs lacked adequate goals and specification relative to the preferences and strengths identified earlier in Section I. However, when preferences and strengths were identified, an integrative analysis was not always readily apparent (e.g., Individual #77 and Individual #73). One consistent theme that appeared problematic was related to the goal found in many PSIs that reflected a desire to remain at the Facility despite the fact that the individual was non-verbal, appeared to not have completed any community-based residential tours, and/or the fact that the goal was based solely on rationale (preference) provided by the guardian. Since the Monitoring Team's last visit, a PSI Quality Measure Grading Tool was developed to monitor the quality of developed PSIs. This tool included five items targeting whether or not: 1) the PSI was submitted by the deadline; 2) preferences, strengths, and goals coincided with the actual assessment; 3) the summary and analysis sections were completed; 4) the comment area contained recommendations for SAPs; and 5) the findings reflected an accurate assessment of the individual. Summary data was provided that evidenced the use of this tool to ensure quality development of PSIs. That is, data revealed that this tool was used to review 18 PSIs between November 2012 and May 2013. Reported estimates of quality ranged from 40 to 80%. It should be noted that the summary data did not indicate which items were inadequate across assessments and no data was provided to evidence adequate inter-rater reliability. At this time, the Monitoring Team's initial impression of this tool was that it was too brief. More specifically, items on the tool were too broad and might not allow sufficient specification to identify inadequacies in assessments over time. The Facility is encouraged to consider developing additional items that would allow more specification in examining quality of completed assessments. For example, additional items could reflect whether or not the	

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		assessor indicated how the individual was communicating their responses as well as whether or not preferences and strengths were listed following each section of the assessment as prescribed. In addition, the current items could be split into items that more specifically examined separate areas of the report. Ultimately, these changes are likely to occur once independent raters begin to examine inter-rater reliability and learn which areas of the assessment and quality tool require more specification. Of the 14 individuals in the sample, documentation evidenced completion of FSAs within the past 12 months for 14 (100%) individuals. In addition, of these, 13 (93%) appeared to have been completed prior to the ISP. The exception was the FSA for Individual #46. Of the 14 individuals sampled, only eight (57%) FSAs appeared to be adequately completed. More specifically, the FSAs for six individuals did not evidence adequate completion of items within the assessment and/or contained incomplete summaries of strengths and needs (Individual #306 and Individual #202). Other FSAs appeared to be missing recommendations related to residential SAPs or omitted QDDP recommendations, life skills, and/or wellness sections (Individual #284, Individual #46, Individual #70, and Individual #183). Lastly, it should be noted none (0%) of the reviewed FSAs contained the newly revised ending pages that: 1) identified preferences and strengths; 2) identified tentative goals; 3) identified barriers to community integration and supports needed to overcome barriers; 4) offered recommendations for SAPs; 5) made recommendations for service objectives; and 6) provided other recommendations. Since the Monitoring Team's last visit, a FSA Quality Measure Grading Tool was developed to monitor the quality of developed FSAs. This tool was very similar to the one developed to estimate the quality of PSIs (as described above). That is, this tool included five items targeting whether or not: 1) the FSA was submitted by the deadline; 2) the FSA summary coincided with the actual assessment; 3) the strengths and needs sections were completed; 4) the comment area contained recommendations for SAPs; and 5) the findings reflected an accurate assessment of the individual. Summary data was provided that evidenced the use of this tool to ensure quality development of FSAs. That is, data revealed that this tool was used to review 36 FSAs between December 2012 and May 2013. Reported estimates of quality ranged from 20 to 100% with the majority of FSAs (i.e., approximately 75%), rated by one or more assessors, estimated below 80%. Summary data also appeared to indicate that multiple assessors rated the same FSAs using the quality tool in an attempt to examine inter-rater reliability. More specifically, multiple scores were reported for 30 (83%) of the 36 completed quality tools. When comparing the estimates generated by the multiple assessors, it appeared that the independent raters reported the same estimate in only six (20%) of those FSAs reviewed. Currently, as similar to the finding described above, the Monitoring Team found this tool to be inadequate. More specifically, items on the tool were too broad and did not appear	

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		to allow sufficient specification to identify inadequacies in SFAs over time. The Facility is encouraged to consider developing additional items that would allow more specification in examining quality of completed assessments. This should include items that would more closely reflect recent changes in the recently develop ending pages (as previously described). Based on verbal report and provided documentation, it appeared that 111 vocational assessments had been completed over the past six months. A provided sample of 10 recently completed (in May 2013) vocational assessments was reviewed. This sample represented approximately 9% of the vocational assessments completed over the past six months. Of the 10 assessments reviewed, two (20%) appeared to be adequately completed. That is, one or more of the content areas appeared inadequate across eight of the individuals reviewed. As found in the Monitoring Team's previous report, concerns were noted regarding the adequacy of the summary sections found within reviewed reports. More specifically, only six (60%) of the sampled vocational assessments had an adequate "vocational/employment" vision (i.e., Individual #300, Individual #126, Individual #173, Individual #137, Individual #181, and Individual #185). The exceptions were assessments that did not describe an actual vision, but rather primarily identified preferences (Individual #321, Individual #79), responses of others (Individual #320), or did not appear to offer any vision (Individual #217). In addition, only three (30%) appeared to offer adequate "ideas for the future," including those for Individual #137, Individual #185, and Individual #217. The exceptions included those individuals with descriptions that did not appear related to the vision or referenced ideas that appeared more relevant to residential placement than a vocational setting. Only three (30%) listed several goals along with cited preferences and strengths (as previously identified by the IDT). These included the assessments for Individual #137, Individual #181, and Individual #320. Lastly, current vocational assessments continued to appear inadequate with regard to the completion of vocational explorations. That is, three (30%) of the individuals were identified for vocational explorations, and, of these three, only one (33%) appeared adequately completed (Individual #137). The exceptions included Individual #320 where there appeared to be inconsistency between identified preference/vision and the experience targeted as part of the vocational exploration. More specifically, although the assessment identified preferences working with arts and crafts (Ceramics), the situational assessment targeted a job activity (newspaper rolls) that the individual had previously experienced. In addition, despite recommendations against conducting vocational explorations (found earlier in the report), a situational assessment was conducted with Individual #173. And, when the exploration was completed, it did not involve job activities that were consistent with those previously identified by the individual within the employment vision. These findings were consistent with findings noted in the Monitoring Team's previous	

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		reports, and given the similar limitations and inadequacies as described above, the Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure the completion of quality PSIs and FSAs by ameliorating inadequacies as identified above. In addition, the Monitoring Team recommends substantial revision of the quality tools used to examine the quality of PSIs and FSAs.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As previously discussed (with regard to Section S.1 of the Settlement Agreement), evidence indicated that needs related to SAPs were adequately identified in 12 (86%) 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. Based on review of available assessments, of the 14 SAPs reviewed, it appeared that 11 (79%) identified one or more assessments as the basis of the targeted need. Of these 11, two (18%) appeared consistent with the findings of those assessments. Overall, 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. In an effort to examine whether or not SAPs were practical and functional in the most integrated setting, the prescribed settings of sampled SAPs were examined. This was the same sample as described with regard to Section S.1 of the Settlement Agreement. Of the 14 SAPs reviewed, it appeared that all (100%) of the SAPs prescribed a training setting that appeared consistent with the natural setting the targeted skill would likely be observed. In addition, as described with regard to Section S.3.b of the Settlement Agreement, of the 14 individuals sampled, 11 (79%) individuals had one or more SAPs that identified the community as a potential setting to facilitate generalization. In addition, 13 (93%) appeared to have SAPs that were practical and functional. More specifically, most SAPs appeared to target skills that were meaningful and potentially productive. The exception was the SAP for Individual #242 that targeted increasing verbal responding to a question, and the SAP for Individual #284 that targeted pacing at meals. Although these appeared important skills, it was unlikely that staff could prompt correct responding. Although the majority of SAPs appeared to target skills that were	Noncompliance

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		useful and meaningful, significant concerns remained regarding the adequacy of sampled SAPs (more detailed findings are provided with regard to Section S.1 of the Settlement Agreement).	
	(b) Include to the degree practicable training opportunities in community settings.	Slight progress was noted in the development of skill acquisition programs designed to provide training opportunities in community settings. Findings from previous Monitoring Team reviews consistently demonstrated inadequacy in providing training opportunities within community settings for individuals served by the Facility. That is, only a small percentage of reviewed SAPs specifically prescribed implementation of SAPs in community settings. Indeed, as reported in the Monitoring Team's previous report, of the 55 SAPs reviewed at that time, only 16% included instructions to promote completion off-campus. And, only 64% of the individuals sampled had a SAP that targeted implementation in a community setting. At the time, it was noted that many of these SAPs only identified community settings through generalization strategies, and, as a result, these individuals only received limited opportunities to formally engage in training opportunities in community settings. Currently, as previously presented with regard to Section S.1 of the Settlement Agreement, a random sample of completed SAPs from 14 individuals who had an Individual Support Plan meeting over the past six months were selected for review. Overall, a total of 57 SAPs provided for these individuals were reviewed and it was found that three (5%) specifically targeted the community as the primary setting for training. That is, three SAPs identified the community (or a specific community-based setting) as the primary environment were training should occur. These SAPs were found across three (21%) of the individuals sampled (i.e., Individual #127, Individual #46, and Individual #70). In addition, the community (or a specific community-based setting) was also identified as a setting for implementation within strategies listed to promote generalization in some SAPs as well. That is, of the 14 individuals sampled, 11 (79%) individuals had one or more SAPs that identified the community as a potential setting to facilitate generalization. It should be noted that, when identified in the generalization section, strategies related to community-based implementation were vague and did not typically included specific instructions for generalization and usually encouraged implementation only after the skill was acquired. Overall, although awareness of the importance of training opportunities in community settings appeared to improve, adequate and sufficient opportunities for training in community settings did not appear evident within the current sample of SAPs. Lastly, although noted in several monitoring reports, there continued to be no systematic method for monitoring SAPs targeted for completion in the community as well as individual performance on these over time.	Noncompliance

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		To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility provide more specific descriptors of community settings, more detailed instructions, and encourage the provision of opportunities for generalization both during and following skill acquisition. More importantly, the Facility should consider targeting community-based settings as the primary environment for training and, although important, not just as one potential method to promote generalization. And, a monitoring system to effectively track progress on these community-based training opportunities should be developed and implemented. Provided documentation reported an acknowledgement of this inadequacy and proposed a plan (i.e., including changing the schedules and responsibilities of two night-time supervisors) to develop systems to help ensure and monitor the accurate completion of SAPs in the community. As reported in the Monitoring Team's previous reports, summary data of community outings reflected insufficient opportunities for community outings for many individuals served by the Facility. For example, provided summary data from 9/11 to 2/12 and 3/12 to 9/12 indicated an overall range of 54 to 165 and 70 to 114 total outings per month, respectively, across all residential programs. This data also consistently showed that several programs typically reported no (or minimal) community outings each month. These included Quail, Sparrow, Iris, Zinnia, and Willow. Currently, community outing data reported between September 2012 and May 2013 was relatively consistent with previously reported findings. More specifically, provided data reflected a range of 50 to 96 community outings per month. This data evidenced missing data across all programs during the months of March and April 2013. In addition, data continued to reflect no (or minimal) community outings each month for Quail, Sparrow, Iris, Zinnia, Oak and Willow. Overall, no significant progress in addressing inadequacies in providing opportunities for community outings was noted since the Monitoring Team's last visit. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that all residential programs are providing consistent opportunities for community outings.	

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: "There have not been any additional state or facility policies or procedures related to assessment of individuals for community placement since the last review in October 2012;" o LBSSLC Self-Assessment, updated 6/20/13; o List of individuals referred for placement, undated; o List of individuals who have requested community placement, but have not been referred, undated; o List of individuals not referred due to Legally Authorized Representative (LAR) preference, data pulled from 11/15/12 to 5/15/13; o List of individuals transferred to the community since the last onsite review, undated; 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 A current list of alleged offenders committed to the Facility, undated; o Minutes from meetings between the QA Department and the Admissions Placement and/or Transition Specialist staff, dated1/17/13, 2/28/13, 3/20/13, 4/17/13, and 5/15/13; o Over the last one year period, the unduplicated number of individuals that have participated in Community Living Options Information Process (CLOIP) tours and staff that have participated in CLOIP tours; 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, from 11/15/12 to 5/15/13; o Facility and Local Authority (LA) staff training curricula related to community living, transition, and discharge, including training materials; o For the past six months, a list of all training and educational opportunities for staff that address community living, including training materials and sign-in sheets; o For the past six months, documents provided to staff to inform them of community living options; o Since the last onsite review, a list of individuals who have had a community living discharge plan developed, undated; o ISP Meeting Guide, dated 11/20/12; o Annual Report: Obstacles to Transition Lubbock State Supported Living Center, Fiscal Year 2012, prepared November 2012;

	o Center Strategies and Actions to Overcome or Reduce Obstacles, QA/QI Meeting, 2/13/13; o Since the last review, a list of individuals who have returned from a community placement, and documentation of the Facility's review and assessment of each case (i.e. for Individual #197); 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; o In response to a request for any individuals had moved to the community since 7/1/02 and who had died, the statement: "There isn't anyone who has moved from LBSSLC since 7/1/09 that has died;" o Community Placement Report, from 8/22/12 through 2/23/12; o Community Placement Report, from 8/22/12 through 6/30/13; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o Community Living Discharge Plan, related assessments, sign-in sheet, and most recent ISP for: Individual #92, Individual #2, Individual #61, and Individual #124; o For the CLDPs provided, the 45-day assessment tracking logs; o List of all post-move monitoring visits, including the dates for each of the completed visits, undated; o Individual Support Plans, sign-in sheets, Annual Integrated Risk Rating Forms, Annual Integrated Health Care Plan, Skill Acquisition Program, ISP Preparation Meeting documentation, assessments completed for the ISP meeting, for the following individuals: Individual #30, Individual #242, Individual #290, and Individual #276; o Pre-Move and/or Post-Move Monitoring Checklists for: Individual #197, Individual #257, Individual #121, Individual #92, and Individual #2; o A statement that State Office reviews had not been conducted for any of the CLDPs; o Last 10 monitoring tools completed by: 1) the QA Department; and 2) the Admissions Placement Department, various dates; o Based on monitoring data or other reviews related to provision of supports in the most integrated setting, reports showing analysis of such data, as well as descriptions of actions taken or action plans or corrective action plans developed; o ISPAs and other documentation of transition planning for Individual #264; o Progress Notes from Post-Move Monitor regarding Individual #121's return to the Facility,

	and documentation of IDT meetings; o Pie charts for Provider Fair data; o Special Review Team documentation for Individual #124; o PowerPoint from State Office to be shown to self-advocates regarding community options; and o Presentation Book for Section T. ▪ **Interviews with**: o Carla Prell, Admissions/Placement Coordinator; Annette Webster, Post-Move Monitor; and Georgia Howard, Transition Specialist; and o Sandra Kennedy, QDDP Coordinator; Christina De Los Santos, QDDP Educator; Jessica Smith, QDDP Educator; Marc Lopez, ISP Technician; and Ric Savage, State Office Consultant. ▪ **Observations of**: o ISP meetings for the following: Individual #290, and Individual #276; o ISP Preparation Meeting for Individual #3.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 6/20/13. 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. As one example, 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. 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, but did not consistently identify 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, the Transition Specialists had begun to play a monitoring role, as did the Admissions Placement Coordinator. The Program Compliance Monitor also conducted monitoring. 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 all of the various tools. ▪ Used other relevant data sources. For example, for Section T.1.b.2, 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. 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 a positive note, the findings generally were presented based on specific, measurable indicators, as opposed to overall compliance scores. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section T: T.1.c, which is an overarching provision related to the development of CLDPs; T.1.c.1, which requires definition of action steps to be taken by the SSLC and provider staff; 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.d, which requires the completion of comprehensive assessments within 45 days of transition; T.1.e, which requires the development of CLDPs with pre- and post-move required supports, as well as the confirmation of pre-move supports prior to transition; T.1.f, which requires development and implementation of a quality assurance system; 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. The majority of these findings were not 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: Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community. In addition, individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. Based on observations of ISP meetings, when team members modified the opinions they had included in their assessments, generally no explanation was provided. During the interview with staff from the Admissions Placement Department, staff indicated that some individuals had been removed from the referral list due to family members becoming guardians and rescinding the referrals. Of concern, staff stated that the Admissions Placement Department had told teams to work on educating family members prior to making a referral to convince them to become guardian before the referrals were made. As the State Office staff member observing the interview pointed out, other Facilities were approaching this differently, and having the Transition Specialists work with family member that were not guardians, but had concerns about transition. The Transition Specialists at other Facilities were, for example, identifying the family members' concerns in more detail, and assisting in

	answering questions and identifying community providers that had a record of providing specific supports that family members might not think were available in community settings. As opposed to LBSSLC's stated approach, this latter approach was consistent with the portion of this provision of the Settlement Agreement that required the State to: "take action to encourage and assist individuals to move to the most integrated settings…" Although teams were identifying obstacles to referral, they often did not include all of the concerns the team had identified in their discussion. This resulted in action plans not being developed for all obstacles. In addition, action plans that were being developed were poor in that they often did not address the underlying issue, and were not individualized. It remained unclear if teams were regularly identifying obstacles to transition. Similarly, the Facility continued to provide a number of educational opportunities to individuals and their families. However, an ongoing concern was the lack of individualization of action plans related to expanding individuals and their guardian's knowledge of supports in the community that could meet their needs. 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. Based on review of documentation related to potentially negative outcomes for individuals that had transitioned to the community, eight of 10 individuals had been involved in one or more incident. In recent months, three individuals that had transitioned to the community since the Settlement Agreement was signed had returned to the Facility, and two of these individuals were in jail before returning. Although further analysis of this information would be needed to draw conclusions, the Facility was not conducting root cause analysis reviews of even the most critical incidents. This was an important and missing component of the quality assurance system for Section T. Although different reasons likely existed for the various individuals' experiences, it is very important that critical reviews of these situations be conducted to determine what, if anything, could be done from the perspective of the transition process and/or the community system to prevent similar outcomes in the future for these or other individuals. 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. Post-move monitoring had been completed in a timely manner. Although it was clear that efforts were being made to conduct thorough post-move monitoring, 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.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United 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 ISP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from LBSSLC, funding availability was not cited as a barrier to individuals moving to the community. As noted in the previous report, 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. 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. Justification needed to be provided for any transitions that were anticipated to take longer than the 180-day timeframe. Based on the most recent Community Placement Report for data from 8/22/12 to 6/30/13, a total of eight individuals had been referred to the community, and two individuals were listed as having been referred to the community for 180 days or more. However, one of these individuals (referred in January 2013) had moved to the community the week prior to the onsite review. The remaining individual had been referred in October 2012. A third individual had been referred in January 2013, and the 180 days would elapse shortly after the Monitoring Team's onsite review. Based on conversations with Admissions Placement Department staff, it appeared that	Noncompliance

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		delays were due to identifying providers that the individuals or guardians preferred, and who could provide needed supports. 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. As discussed with regard to Section F, a limited review was conducted of ISPs in order for the Monitoring Team to provide more specific feedback on the most recent ISPs. The most recent format specifically required professionals on the team to make an independent recommendation to the individual and his/her guardian. In addition, as discussed in detail with regard to Section F, the Facility had implemented a "back page" for assessments that prompted all assessors to provide a recommendation regarding the individuals' appropriateness for transition to a more integrated setting. A total of four plans were reviewed including those for Individual #30, Individual #242, Individual #290, and Individual #276. Based on this review: ▪ Of the four ISPs reviewed and/or meetings observed, none of the individuals were referred for transition to the community. ▪ For these four individuals, team disagreements were noted in either the ISP document or the assessments for all four individuals (100%). As noted below, during the ISP meeting, Individual #276's team could not reach consensus regarding a recommendation to the individual and guardian. However, for the remaining three individuals, it was not clear how the team disagreements had been resolved for any of these individuals. ▪ Three individuals' ISPs (75%) included a recommendation from the professionals on the team to the individual and LAR. For Individual #276, the IDT could not reach consensus. For none of the remaining three individuals (0%) was adequate justification provided for the team's recommendation. As also noted above, team disagreements often were not reconciled in the final recommendation. During the interview with staff from the Admissions Placement Department, staff indicated that some individuals had been removed from the referral list due to family members becoming guardians and rescinding the referrals. Of concern, staff stated that the Admissions Placement Department had told teams to provide family members who wanted to become guardians to prevent a referral with time to become guardians before	

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		the referrals were made. As the State Office staff member observing the interview pointed out, other Facilities were approaching this differently, and having the Transition Specialists work with family member that were not guardians, but had concerns about transition. The Transition Specialists at other Facilities were, for example, identifying the family members' concerns in more detail, and assisting in answering questions and identifying community providers that had a record of providing specific supports that family members might not think were available in community settings. As opposed to LBSSLC's stated approach, this latter approach was consistent with the portion of this provision of the Settlement Agreement that required the State to: "take action to encourage and assist individuals to move to the most integrated settings…" In fact, per State Office guidance, professional team members are to come to an independent recommendation, and then consider the individual and guardian's opinion(s). Certainly family members who are not guardians should be able to voice an opinion, but if the team believes the person can be supported in a more integrated setting, a referral should be made. This should not be dependent on if a family member has indicated they want to become guardian to prevent a referral. In reviewing CLDPs and ISPs of those individuals that were referred, none of them or their guardians had opposed transition to the community. 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. Based on documentation submitted, since the last review, changes had not been made to the Facility's policies and procedures for this section. However, it was anticipated that the State Office was going to issue an updated policy related to Most Integrated Setting that likely would require modifications to be made to Facility policies. As noted in previous reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy, and on 5/16/11, had submitted comments for the State's consideration. It was anticipated that the State would address the Monitoring Teams' concerns in the revised version of the policy. 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	Noncompliance

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		to transition and discharge processes, the Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	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 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, 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	Noncompliance

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		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 Referral and Transition to Community</u> The revised ISP format included a section on obstacles identified by the IDT. It included 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. In reviewing the sample of four ISPs, observing two of these individuals' ISP meetings, and reviewing related documentation, teams discussed and identified some obstacles to referral. Of the four ISPs, three should have had obstacles to referral defined, because none of the individuals had been referred to the community, but one individual's team could not reach consensus about whether to make a referral or not (i.e., Individual #276). Of the four plans, none (0%) adequately defined obstacles. 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 #290's medical issues without the specific supports the individual needed that could not be provided in the community being defined, Individual #242's medical as well as behavioral/psychiatric issues, and Individual#30's behavioral issues); ▪ When guardians objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #290, Individual #242, and Individual #30). 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 not identifying a second obstacle was not clear. For Individual #30, the Facility discipline team members did not recommend transition and concluded that: "This determination is based on the recent re-emergence of [Individual's] fecal smearing and urinating on the walls and personal possessions in [Individual's] bedroom. He also has fecal smearing issues while at school... The IDT felt that [Individual] had made progress since coming to the facility but that [Individual] still needed some additional time to completely stabilize... It was agreed that more time was needed in order for [Individual] to have the best chance for successful community integration..." However, the only obstacle the team checked was "LAR Choice." Given that the team did not recommend referral, and based on the ISP documentation, this was due to their belief that he needed to remain at	

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		the Facility to further stabilize his behaviors, it was unclear why "Behavioral Health/Psychiatric Issues" was not identified as an obstacle. This further called into question the team's recommendation, because if this was not an obstacle (i.e., supports were available in the community to address his behavioral needs), it was unclear why the team did not recommend referral. Based on information in the Presentation Book for Section T and interview with staff, new AVATAR forms had been developed to capture some additional information related to the Living Options Discussion, including obstacles to referral. More specifically, the new form was designed to capture the specific reasons for an individual or LAR's reluctance to make a referral. The Facility indicated that this should better inform the analysis of those identified obstacles as well as assist in the development of action plans to overcome obstacles. The Monitoring Team is less optimistic. The list now included in AVATAR is the same list that had been included in the ISP template. It provides little insight into the specific reasons for the individual or LAR's reluctance, and has limited utility in conducting the analysis necessary. Moreover, action plans to overcome the obstacles to referrals generally were not adequate. ▪ Of the four ISPs, four (100%) included an action plan to overcome obstacles identified (i.e., even though Individual #276's team could not reach consensus about whether or not to make a referral, and action plan related to education about community options was included. Of concern, despite the fact that the Transition Specialist and LA representative recommended further investigation of what providers could offer, the team did not develop an action plan to pursue obtaining further information.). ▪ Of these four, none (0%) were adequate. o On a positive note, plans were not generally measurable. o The plans were not adequately individualized. Many of the plans included action involving the individual attending provider fairs and Community Tours, or LA staff contacting the guardian about living options annually. These did not specifically address the individuals' needs by, for example, tailoring visits to show the individual options that might meet his/her needs, identifying tools that could be used to assist an individual to learn about options that would be meaningful to him/her, or for an individual who could not verbally express his/her opinion identifying how the team would determine the individual's choice; o At times, the plan did not address the stated obstacle and/or the underlying issues [e.g., for Individual #290, the team's major concern appeared to be the availability of medical supports, but no action steps	

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		were included to determine whether or not such supports would be available in the community, only if they would be available at a different SSLC; and for Individual #242, They did not address the underlying issue that the team believed supports were not available to address her psychiatric and medical issues (e.g., research to determine if community providers had this capacity, visits to providers supporting individuals with similar needs, work with Transition Specialists to determine if providers could develop such capacity if it did not exist, etc.)]. 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 should involve staff action as opposed to guardian or individual action. However, this was not seen, for example, for Individual #30. Of concern, in the Presentation Book, the Facility identified the ISP for Individual #30 as one that offered: "a representative discussion regarding needed protections, services, and supports, the identification of obstacles to movement and the strategies developed to overcome the obstacles." Given that numerous concerns were identified with regard to this ISP in relation to these factors, it was concerning that the Facility put it forward as a representative example. Although Individual #30 is used as an example elsewhere in this section, the following summarizes the Monitoring Team's concerns: ▪ At the ISP meeting, the professional members of the team recommended that Individual #30 not be referred to the community. However, the differences of opinions in the assessments (i.e., most assessors had said he could be referred for transition) were not explained or reconciled. The team stated: "This determination is based on the recent re-emergence of [Individual's] fecal smearing and urinating on the walls and personal possessions in [Individual's] bedroom. He also has fecal smearing issues while at school... The IDT felt that [Individual] had made progress since coming to the facility but that [Individual] still needed some additional time to completely stabilize... It was agreed that more time was needed in order for [Individual] to have the best chance for successful community integration..." Given that the individual's behaviors should be able to be addressed in a community setting as effectively as in a large ICF/ID setting, it was unclear what the basis was for the team's recommendation. The only obstacle the team checked was "LAR Choice." Given that the team did	

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		not recommend referral, and based on the ISP documentation, this was due to their belief that he needed to remain at the Facility to further stabilize his behaviors, it was unclear why "Behavioral Health/Psychiatric Issues" was not identified as an obstacle. This further called into question the team's recommendation, because if this was not an obstacle (i.e., supports were available in the community to address his behavioral needs), it was unclear why the team did not recommend referral. Moreover, based on the ISP, the team had not identified the specific reasons for the guardian's reluctance to make a referral to the community. The plan to overcome the obstacles was what appeared to have become the "cookie cutter" plan, which involved attendance on community tours, attendance at the Provider Fair (s), and contact with the guardian. Although the steps in his action plan were measurable, none of this was individualized, and, for example, did not address the need for the identification of a provider with good options for providing behavioral supports. The Facility's status with regard to documenting obstacles to transition remained somewhat unclear. 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, it was not clear that a system had been operationalized. Anecdotally, some individuals had encountered obstacles to transition, but based on interview, it did not appear these were being consistently identified as obstacles, and documented as such. 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. LBSSLC had essentially maintained its previous status with regard to identifying obstacles to community referral and transition, and more work was needed. The quality of the plans teams had developed to overcome such obstacles remained inadequate. Plans had become more measurable, which was positive. However, they continued to lack individualization, and often did not address the underlying obstacle/issue. These deficiencies, 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	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	Noncompliance

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	community placements to individuals and their families or guardians to enable them to make informed choices.	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 September 8, 2012, and another recently had been held on March 7, 2013. Prior to the fair, one of the Local Authorities sent invitations to all of the local providers. A postcard was sent to all individuals' correspondents, and the Transition Specialists visited each residence on campus and gave individuals tickets to create a fun atmosphere. The theme for the Provider Fair was a carnival. Letters were sent to staff, and flyers advertised the Provider Fair. During the Fair, providers offered educational games to people attending. Based on data the Facility provided, there were eight providers. Participants at the March fair included 80 individuals, five Legally Authorized Representatives, 33 direct support professionals, 67 "professional staff," and 32 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). A graph also was submitted that showed a comparison of attendance between the September 2012 and March 2013 fairs. Attendance generally had increased, except for LARs, for whom it had decreased by half (i.e., from 10 to five). 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 (i.e., what worked to increase attendance for some and not others), or if different evaluation questions needed to be asked. ▪ **Education about community options:** Individuals and their guardians also were provided information through the following: o Based on review of ISPs, the Local Authority CLOIP process appeared to have 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 agreed to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refused to participate in the CLOIP process. Collection and review of such outcome data would allow the State to evaluate the effects of the process and make changes made to future educational activities. o Transition Specialists were attending some ISP Preparation and ISP meetings to provide information on living options to individuals and their families/guardians. In addition, they had developed resource	

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		directories to describe the services that all community providers in the area offered. ▪ **Tours of community providers**: Based on data the Facility provided, between December 2012 and May 2013, eight community provider tours were conducted. Three other scheduled tours were cancelled due to inclement weather. 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. Based on data the Facility provided, over the last one-year period (exact dates were not provided) 47 individuals went on community exposure tours. At times, these appeared to be large groups of individuals. For example, between six and eight 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. Since the last review, a form had been developed for staff to record individuals' responses to the community tours. This was positive. The Admissions Placement Department maintained this information, and shared it with the QDDPs. The information would be made available to teams to allow discussion of individuals' reactions to various alternatives. 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. Although the Facility referred the Monitoring Team to minutes from the Admissions Placement Department meetings for discussion about community exposure tours, the sample provided in the Presentation Book did not include this level of analysis. It was positive to see that the Facility had begun to document the individual's reaction. However, the use of this information was not yet evident, for example, in ISPs, and it was unclear 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. With regard to community	

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		exposure tours, the Facility also was tracking the staff, including their titles that participated in the community tours, as well as the provider fair. It was not clear if data regarding staff training were being aggregated and analyzed. New Employee Orientation continued to include a component on the most integrated setting. The Admissions Placement Coordinator provided a component of the On-the-Job training for new QDDPs. In April and May 2013, the Transition Specialists had met with each IDT on campus to review their roles and the Living Options process. On March 25, 2013, the Admissions Placement Coordinator provided training to the Psychology Department on the assessment format. Other training sheets were provided showing that the most integrated setting topic was combined with others to address the needs of specific groups of staff. The Transition Specialist and/or Admissions Placement Coordinator also attended some QDDP meetings (e.g., on 11/19/12, 2/21/13, and 5/15/13), and provided information and training on topics related to the most integrated setting. In addition, in October 26, 2012, the Local Authority provided 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:** Individuals, staff, and families had some other opportunities for learning more about community options. At the provider fair in September 2012, an individual that had recently transitioned spoke. This was a positive way to share an individual's success story. In addition, since the last review, a creative educational option occurred at the Diner on weeks when community tours were not occurring. Based on information provided these opportunities had been occurring since April 2013. Some examples were provided with numbers of individuals and staff participating, including on 5/24/13, when 26 individuals and staff participated; on 6/7/13, when 18 individuals and staff participated; and on 6/21/13, when 15 individuals and staff participated. The topics varied, and included, for example, presentation of the provider directory, introduction to the work of the Transition Specialists, viewing of educational videos, and the Self-Advocates presentation on living options. The Facility's staff newsletter was being used to advertise community tours, as well as Diner discussions and the Provider Fair. However, the following were areas that the Facility had not yet addressed fully: 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	

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		who live in community. Although the Facility indicated that individuals and guardians were able to interact with individuals who had moved during pre-selection visits and community exposure tours, more could be done to provide opportunities for more individualized visits; 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. Based on information provided, in January, February, March and May, the related topics covered were community exposure tours and community integration. It was anticipated that at an upcoming meeting, a PowerPoint presentation from State Office on Living Options would be shared with the Self-Advocacy Group. Based on review of the PowerPoint presentation, it appeared to provide some good information, including pictures of community homes, and it might generate further discussion about options. The Admissions Placement Coordinator also presented at Family Association meetings. Since the last review, some effort had been made to expand the topics discussed (e.g., in addition to community exposure tours, the Provider Fair, and "updates on Most Integrated Settings"). These meetings had occurred on 12/9/12, 3/10/13, and 6/9/13. The Admissions Placement Coordinator indicated that some of the Association's board members had agreed to participate in a tour of some community homes and programs. The Facility did yet indicate house meetings were forums in which education regarding community options was occurring. ▪ **Regular SSLC meeting with the Local Authority:** Based on interview with staff, 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, provider fairs, new educational opportunities in which the LA could be involved, and the flow of information back and forth between the LA and the Facility. In October 2013, it was anticipated that the LA Living Options training would involve a "CLOIP Feud," similar to "Family Feud," at which teams would compete to answer	

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		questions. This was a creative approach to keep people interested in training that occurred annually. ▪ **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 four recently completed ISPs and related documentation, four (100%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following provides additional specific information: o None of the plans (0%) 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' specific 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 and/or the team's concerns. For example, if an LAR has questions or concerns about the specific supports available in the community, identifying providers with 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. When teams have questions about availability of supports in community settings, these should be researched. At the time of the review, these types of activities were not included in action plans. Creative ideas and brainstorming within LBSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. o All of the plans (100%) included some measurable components. For example, many of the plans involved participation in community tours, and identified how many or when these would occur. However, methodologies were not 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). Generally, specific strategies were not included to obtain the individual's reaction at the time or shortly after an educational opportunity. Although the Facility had developed a standard practice for this, it will be important to individualize these practices, as necessary. o Two of the four plans (50%) (i.e., Individual #290, and Individual #276)	

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		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. 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 Facility was implementing the State Office's process to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. The Facility recently had added a "back page" that was to be included at the end of each assessment. It prompted the assessors to make a recommendation related to community transition. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. The newer format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. Four plans were reviewed including those for: Individual #290, Individual #276, Individual #30, and Individual #242. Based on the review of records: ▪ Of the four ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. Those individuals whose assessments did not all include recommendations were Individual #242, Individual #290, and Individual #30. For Individual #276, a number of assessments were missing, so this could not be adequately assessed. This had definitely improved over time, but the ones that sometimes did not include a statement were nursing, day support, dental (who often did not make a specific recommendation, but would state what might be problematic in a community setting, such as the need for IV sedation), functional skills assessments, and recreation. The ISP Workgroup's addition of the assessment "back page" should assist in continuing to improve this piece. ▪ Of the four ISPs reviewed, none of the individuals had been referred for transition to the community. Three individuals' ISPs (75%) included a recommendation from the professionals on the team to the individual and LAR. For Individual #276, the IDT could not reach consensus. Although the template of the ISP indicated that this would require notification of the Facility Director within one day, the ISP document did not specifically state that the team intended to notify the Director. For none of the remaining three individuals	Noncompliance

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		(0%) was adequate justification provided for the team's recommendation. The following provide examples of the problems identified: o For Individual #290, The ISP indicated that seven professionals on the team indicated that Individual #290 could be supported in a less restrictive setting, and three did not. Observation of the meeting showed that the team members discussed the reasons for the recommendations against community transition. Of note, this did not appear to be a very informed discussion, and largely relied on speculation about what was not available in community programs with regard to supports for individuals with active seizure disorders. The QDDP conducted a re-polling of team members, and all those who had originally said he could be supported in a less restrictive setting had changed their minds. Based on observation as well as reviews of the final ISP, specific reasons for their changing their minds were not provided. It appeared that once the team began discussing the possibility of his moving to another SSLC, the option of the community was not given much further consideration. o At the ISP meeting, the professional members of the team recommended that Individual #30 not be referred to the community. However, the differences of opinions in the assessments (i.e., most assessors had said he could be referred for transition) were not explained or reconciled. The team stated: "This determination is based on the recent re-emergence of [Individual's] fecal smearing and urinating on the walls and personal possessions in [Individual's] bedroom. He also has fecal smearing issues while at school... The IDT felt that [Individual] had made progress since coming to the facility but that [Individual] still needed some additional time to completely stabilize... It was agreed that more time was needed in order for [Individual] to have the best chance for successful community integration..." Given that the individual's behaviors that the team described should be able to be addressed in a community setting as effectively as in a large ICF/ID setting, it was unclear what the basis was for the team's recommendation. o Some members of the team for Individual #242 indicated in their assessments that she could be supported in a less restrictive setting and other did not. However, these various opinions were not reconciled in the Living Options discussion as documented in the ISP. The Facility discipline members of the team made the recommendation not to refer her, and indicated: "This determination is made based on her rapid cycling bipolar disorder and having C-diff and VRE [vancomycin-resistant enterococci] in the recent months. The team does not feel [Individual] would benefit from any changes at this time. [Individual]	

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		has expressed no preference for living environment but does prefer to be with familiar people that can anticipate her wants and needs. [Guardian] and sister wants [Individual] to remain at Lubbock SSLC." In addition to this recommendation not being independent of the individual and guardian, it provided no justification for the reasons the Facility staff believed supports could not be provided in the community to support someone with bipolar disorder and infections. As the Monitoring Team had recommended, for some individuals for whom their teams believed transition would be appropriate "if appropriate supports were available," teams should consider an exploratory phase prior to making a decision about a referral or no referral. During this time, the team could ensure that it had an exhaustive list of protections, supports, and services the individual required, and use this list to determine which community providers might be able to support the individual. The team could support the individual and his/her guardian to explore these different options to determine if they meet the needs as well as the preferences of the individual. To ensure that this process occurred expeditiously, an action plan should be developed with specific action steps and associated timeframes, and persons responsible. The Facility had made some progress in this area. Specifically, more assessments were including a statement/recommendation regarding whether or not the individual could be supported in a less restrictive environment. Although some problems persisted, the newer ISP format appeared to be assisting professional members to make a specific recommendation independent of the individual and his/her guardian. However, problems were noted with regard to teams documenting a well-supported justification for their decisions when most or all team members stated the individual could be served in a more integrated setting, but the Facility team members recommended to the LAR and/or individual that the individual not be referred. The Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the last review, 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 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. Over the six months prior to the onsite review, three individuals had transitioned to the community. Two of these individuals' CLDPs were reviewed (i.e., Individual #61, and Individual #124). This represented 67% of the relevant CLDPs. With regard to the timeliness of the Community Living Discharge Plans, the two plans	Noncompliance

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		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. This process was easier for Individual #124 for whom the Facility provided a new cover sheet, as well as copies of ISPAs to document the team's discussion of pre- and post-move supports over the course of the time between his referral and transition. The cover sheet was a good addition to the process. 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 two 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: ▪ Many of the plans identified the need for training for community provider staff. This had been improved by providing more information about what would be included in the training. In addition, there was improvement in defining which community provider staff needed to complete the training (e.g., day and residential staff). However, the plans still did not specify which provider staff from the various agencies supporting the individual in his/her new setting needed training (e.g., direct support professionals, management staff, clinicians, etc.). ▪ Similarly, the CLDPs had begun to identify what level of mastery of the information was required (e.g., demonstration of competence, etc.). However, it was unclear how "competency testing" would be measured, and this was particularly challenging when a list of items was associated with a training support. The specific competency check-off forms should have been identified. This was particularly concerning for Individual #124 for whom the CLDP indicated LBSSLC staff would provide competency-based training on the crisis intervention plan. Given that no supports were in place to ensure community provider staff were competent in basic crisis intervention techniques, it was unclear what responsibility LBSSLC would have in terms of teaching provider staff to competency on PMAB, or another recognized crisis intervention program. ▪ Missing from the plans was any requirement that collaboration occur between	Noncompliance

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		the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individuals (e.g., medical staff, nurses, therapists, psychologists, psychiatrists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ The plans did not describe LBSSLC's staff's involvement in evaluating potential sites at which individual would be served. Examples of this depending on the needs of the individual would include Habilitation Therapies staff ensuring adequate accessibility and/or equipment, Behavioral Services Department staff determining if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment (e.g., for individuals who specifically indicated that they liked to walk when they were upset). ▪ None 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. Teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible. ▪ The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of 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.	Both 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	Substantial Compliance

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		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, it was unclear how individuals that had monthly or quarterly follow-up with psychiatrists at LBSSLC had timeframes of six months for an initial psychiatric appointment in the community (e.g., Individual #61). Based on past issues with psychiatric services for individuals that had transitioned, this might be more related to the availability of services as opposed to the needs of the individual. Because teams had provided no clear justification for such decisions, it called them into question 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 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 the two plans reviewed sign-in sheets were provided (100%) to confirm attendance. 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. It appeared that the Facility was maintaining the CLDP document sign-in sheets that showed 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	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	Noncompliance

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	within 45 days prior to the individual's leaving.	significantly lacking. With regard to timeliness, for two of the two individuals' CLDPs reviewed (100%), it appeared that assessments that were submitted had been updated within the 45-day timeframe. The quality of these assessments was lacking. None of the two 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, 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.). ▪ 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.).	

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		This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. The following specific information is repeated here from Section M to provide additional insight in concerns related to assessments. Consistent with the findings from the previous reviews, a number of problematic issues were found in the nursing documentation reviewed for Individual #2, including: ▪ A lack of a comprehensive and specific nursing assessment for an individual who had experienced a stroke five months prior to the individual being discharged/transitioned to the community; ▪ A significant lack of clinical assessments for clinical health indicators, especially addressing being 20 pounds underweight (current weight was noted to be 61 pounds and desired weight range was listed as 80 to 108 pounds) at the time of the discharge/transition to the community; ▪ A lack of an analysis of the individual's health/mental health issues especially regarding change in functioning related to the stroke; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments. This was evidenced by discrepancies in the information that were not identified or corrected prior to the individual's transition. For example, the Nursing Discharge Summary, dated 11/13/12, indicated that: "recommendations are to be seen under general anesthesia" for dental care. However, the document entitled In-Service for Individual #2 stated the anesthesiologist had reviewed the individual's record and reported that: "he is not a candidate for general anesthesia due to the change in medical history of the stroke and his recent weight loss." ▪ A lack of clear information addressing the nursing interventions that were needed to care for the individual. 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 individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. Since the last review, progress was continuing to be made. Admissions and Placement Department and Transition Specialist staff were clearly working with individuals' teams to expand the scope and definition of pre-move and post-move required supports. 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	Noncompliance

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	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.	supports that now were included in individuals' ISPs were not addressed in transition plans. Overall, though, 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 neither of the plans reviewed (0%) was a comprehensive set of pre-move and post-move required supports 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 needed to assist the individual to be successful in a particular community environment(s). Once these were listed, the individual's CLDP should identify how they would be provided in the community, by whom, when, with what frequency, and for how long. ▪ An area in which improvement was noted was in supports related to the clinical services (e.g., psychology/behavior, psychiatry, etc.) that were sometimes now referenced in the CLDPs. However, this seemed to vary across disciplines. Psychology, psychiatry, dietary, and medical clinicians often were identified as necessary, and some brief requirements (e.g., qualifications and frequency or review of the individual), but for other clinical supports (e.g., Habilitation Therapy and nursing), no reference was made to the need for individuals to interact with such clinical staff, their roles, or their qualifications. This definition is necessary for all of the clinicians involved with the individual, and needs to address issues such as staff training, review of data, monitoring of the implementation of programs, etc. Across disciplines, 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	

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		supports or habilitation therapy needs, 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. Just to say that the PCP would determine the need for clinical intervention was not sufficient. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans that the Facility had begun to develop, albeit still inadequate, were not reflected in action plans included in the CLDPs reviewed. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. ▪ In addition, clinical supports that LBSSLC was providing, based on assessment information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, although teams had begun to reference nursing care/integrated health care 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. Not even initial appointments with therapists in the community were defined. ▪ 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 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. ▪ The CLDPs had begun to identify the need for treatment plans be implemented (e.g., PBSP, nursing care plans, health management plans, diets, exercise	

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		programs, etc.). However, this was not consistent. ▪ 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, 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. ▪ Although Individual #124's CLDP referenced training on a crisis intervention plan, no requirement was included for collaboration to occur to make any changes to the plan, and it was unclear, as noted above, whether the provider had or would be required to have certified staff in crisis intervention techniques. Given that a number of individuals that recently had transitioned had police contact 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 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. ▪ For Individual #124, the direct support supervision level was specified (i.e., line of sight), which was an improvement. However, 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.	

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		▪ 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. Some 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. Since the last review, the "evidence" column in the CLDPs had shown improvement. Often, it now included concrete documentation or other methods for verifying the existence of the support. Frequently, more than one piece of evidence was listed, such as information gained through interview, as well as verification through observation or record review. In summary, 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. <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 was 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 four individuals' that had transitioned over the six months prior to the onsite review (i.e., Individual #124, Individual #2, Individual #64, and Individual #92). These reviews appeared thorough, and included each pre-move required support listed in the individual's CLDP. Overall, a finding of noncompliance was made for this component of the Settlement	

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		Agreement. Although progress had been made with regard to confirmation of pre-move required supports as well as with the delineation of the pre- and post-move required supports in individuals' CLDPs, many protections, supports, and services continued to be missing from the CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Areas in which progress had been sustained included: ▪ The Facility was conducting monitoring using the tools that had been modified based on the Monitoring Teams' audit tools. Both the QA Department and the Admissions Placement Department/Transition Specialists were responsible for conducting reviews of CLDPs. ▪ The QA Department and the Admissions Placement Department had been meeting monthly to review data. However, based on limited audits of CLDPs, no discussion was documented regarding the quality of the CLDPs. Areas in which continued efforts needed to be made included: ▪ Based on the summary the Facility provided, inter-rater reliability had not been established for monitoring of the CLDPs. Very few CLDPs had been developed, so monitoring had been limited. ▪ 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. ▪ An important part of quality assurance for Section T in relation to the CLDP process will be review of the outcome data for individuals that transition to the community. Analysis should include review of supports that might have prevented potentially 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. The Facility provided data on nine individuals that had transitioned to the community between July 2012 and July 2013. Of these 10 individuals, a total of eight individuals experienced potentially negative outcomes. The following summary is provided. However, it is important to note that further analysis would need to be completed to draw conclusions from the data. Such an analysis should be part of the Facility's QA system: o A total of four individuals moved to different settings in the community. Two of these individuals moved after the Post-Move Monitor identified an inappropriate match with a new housemate. Another individual requested a move, and after moving to a second setting in the community ultimately moved back to LBSSLC. The fourth individual moved to a new setting at the guardian's request. o A total of two individuals moved back to the Facility. As noted above, one of these individuals had moved to a second community setting, and	Noncompliance

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		after police contact and being held in jail, returned to LBSSLC. The second individual returned to the Facility after eloping from a foster care provider and being found by the police. o Six incidents of unauthorized departures involved four individuals. Four of these involved police contact. o In addition to the four police contacts related to unauthorized departures, three additional police contacts involving three individuals related to aggression towards peers or staff, and one also involved aggression towards the police. o Four Emergency Room visits occurred involving four individuals. One individual threatened to call staff in to abuse if 911 was not called, so the nurse called, but he was seen and released; one individual had an infection at the feeding tube site; one had seizure-like activity; and one was taken to the ER after police contact. o One individual was involved in a restraint episode after being aggressive towards other residents. In addition, another individual that had moved to the community since the Monitoring Teams began conducting reviews also recently had returned to the Facility after being arrested for assault and in jail. After his charges were dropped, he moved back to the Facility. When asked for reviews for the individuals that had returned to the Facility, the documentation provided showed a cursory review, and not the type of root cause analysis that such an event should trigger. No discussion was documented regarding the CLDP process, or lessons learned that might assist with other individuals or these individuals in the future. The Facility is strongly encouraged to conduct such reviews in the spirit of identifying ways in which improvements can be made to reduce preventable negative outcomes in the future. Good transition planning requires the commitment of the entire IDT, as well as those tasked with primary responsibility for developing the CLDPs. The entire team should be involved in critical, but constructive reviews of issues that individuals have experienced once they transition to the community. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred. Although the Facility submitted action plans as part of the Presentation Book, it was unclear if these were developed in response to the Facility's internal monitoring, or if the action plans were in response to the Monitoring Team's findings. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should improve its monitoring activities for CLDPs,	

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		including modifying, as appropriate, the monitoring tool, 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 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.	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. Although the report was undated, the State provided it to the Monitors and DOJ on February 26, 2013, six months after the data collection period ended. A number of problems with the report are discussed below. However, the following summarizes some positive aspects of the report: ▪ The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. ▪ DADS included a list of 12 initiatives it was continuing to support. Five were related to the IDT/ISP process and ongoing changes to this process; three were related to working with local authorities and local agencies, including a pilot project with the Austin SSLC; one was related to the Community Living Specialist positions that DADS created using Money Follows the Person funds; one was related to ongoing implementation of existing Home and Community-Based Medicaid Waivers; and two were related to reviewing negative outcomes for individuals that transitioned to the community (i.e., conducting mortality reviews, and reviewing other negative outcomes such as arrests, psychiatric hospitalizations, etc.). In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). ▪ The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: ▪ Section T.1.b.1 of the Settlement Agreement requires that within two years each individual's team "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." It is important to note that the State's definition of obstacles was not consistent with this definition from the Settlement Agreement (i.e., on page 2, the report read: "Obstacles are defined as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs	Noncompliance

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		and preferences of the individual in the alternate setting.") At the time the data for this report was available, the Settlement Agreement had been in the implementation phase for three years, but significant problems continued to be noted with the data available. For example: o As the report indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. For example, for LBSSLC, the total number of obstacles for referral was nine. Given that at the time, according to the Facility-specific report, the census was 214, and in FY 2012, approximately eight individuals were referred for transition to the community, many data were missing. o This might have been complicated by the fact that Table 4 in each of the Facility-specific reports was labeled: "Residents not recommended for movement that prefer to reside in the community from the [Facility Name] State Supported Living Center, 2012." Based on some of the narratives and data provided, it appeared Facilities had interpreted this differently. In some instances, it appeared Facilities had provided data for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community (e.g., Abilene SSLC). However, in other instances, it appeared this data was for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it (e.g., Lubbock SSLC). Both sets of information were important, and the reports certainly should have included the data on obstacles for all individuals the Facilities supported. In Table 7, LBSSLC had listed 85 obstacles to transition, but it was unclear if this was meant to be "obstacles to referral," as opposed to "obstacles to transition." o As the State noted in the report: "Data collected from each respective facility varied, from very detailed obstacle identification/collection to little to no obstacles identified. Within each facility report, a plan for future obstacle identification and collection is provided." Although it was positive that the State recognized the need for improvements with data, at this juncture of the implementation of the Settlement Agreement, it is concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. LBSSLC's plan involved revisions to the data collection system as well as retraining of staff. o As the Monitors discussed with the parties, at this juncture, adequate	

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		methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. For example, as noted above, LBSSLC identified 85 obstacles to transition, but it was not clear that this was the correct data for Table 7. ▪ The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement requires. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. Of note, the LBSSLC facility-specific report provided some additional analysis of the data. However, the actions the Facility would take were largely limited to training staff, and the Facility made no recommendations to DADS in relation to the potential need to expand capacity of certain types of supports and services in the Lubbock area. ▪ The lack of complete data as well as lack of "comprehensive assessment" of the data from the Facilities limited the State's ability to comply with the requirement that: "Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature." Moreover, it was unclear how the State intended to comply with this requirement without conducting and including in the report an analysis on a systemic level of the data the Facilities provided. As noted above, DADS included a list of initiatives it was continuing to support. However, even with the clear problems with full data collection, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred for transition due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals had encountered the following obstacle to transition: "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred to the community due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals had encountered the following obstacle to transition: "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of	

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		available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" ▪ In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS).	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report, for the period between 8/22/12 through 6/30/13. The report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Eight individuals were included on this list. One 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 seven individuals. As noted above, one individual had moved since the list was produced. In addition, two of these individuals had returned to the Facility. ▪ Rescinded Referrals: six individuals were included on this list. The reasons for the referrals being rescinded were "LAR Choice" for three, and "IDT Decision: Behavior/Psychiatric" for three individuals. During December 2010, the Monitoring Panel requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses. For these categories, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the names of five individuals with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: Two individuals were listed in this category, for both of whom "Behavioral/Psychiatric" was listed as the reason. ▪ LAR Prefers Community, Not Referred: No individuals were listed in this	Substantial Compliance

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	paragraph by means of a Facility Report submitted pursuant to Section III.I.	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 25 individuals who the IDT would have referred for transition to the community, if not for the objection of the LAR. It was unclear, however, why in response to a separate document request for "For the last six months, list of all individuals who have not been referred solely due to LAR preference (i.e., whether or not the individual himself or herself requested placement)," a list of 62 names was provided. Given that this was a shorter period of time (i.e., from 11/15/12 to 5/15/13), it should have been a shorter list. This should be corrected or explained for the next review. According to State Office staff, this report also had been provided to the United States Department of Justice.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for the three individuals that had moved in the six months prior to the review (i.e., Individual #64, Individual #2, and Individual #92). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted six reviews. Of the six required visits, six (100%) had been documented as having been completed on time. <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> Based on a review of six post-move monitoring reports, none (0%) were completed thoroughly. The following problems were noted: ▪ At the time of the onsite review, LBSSLC had just begun to use the original form from the Appendix of the Settlement Agreement that State Office was now	Noncompliance

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	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.	requiring. Although the Post-Move Monitor had attempted to provide a narrative description of the evidence she reviewed at the end of the report, there was not a one-to-one correlation between the narrative description and the supports that required review. As a result, the seven-day post-move monitoring report for Individual #64 that used the revised form was determined to be noncompliant. ▪ For supports that required implementation of plans, such as PNMPs or IHCPs, the description of the evidence the Post-Move Monitor review was not sufficient to ensure that all aspects of the plans had been reviewed (e.g., for Individual #2, it was not clear which components of the PNMP were reviewed or how its implementation was assessed). Similarly, the Post-Move Monitor did not appear to review all of the identified evidence for some plans, such as PBSPs (e.g., for Individual #92). As a result, it was not clear that providers were implementing the plans as expected. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the three individuals reviewed, two of them 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 #92. ▪ For one of the two individuals (50%) was documentation presented to show that adequate action had been taken. For Individual #64, serious incidents had occurred, and as a result, he had been moved to a different day program than the one the IDT assisted him to select. It was not clear from the documentation provided what steps his LBSSLC team and/or the Facility had taken to try to address the issues. Although it was clear that efforts were being made to conduct thorough post-move monitoring, 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. 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	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

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	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.		
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in 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. One of these reasons was an individual transferring to another SSLC. In the previous six months, one individual had transferred another SSLC (i.e., Individual #57). Based on a review of the discharge summary completed for Individual #57, each of the requirements of the CMS-required discharge planning process is discussed below:	Substantial Compliance

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	admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	▪ **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). ▪ **The Facility provided a reasonable time to prepare the individual and her parents or guardian for the transfer or discharge (except in emergencies):** Based on the discharge plan, the individual and her family had approximately 30-days notice of the actual discharge date. ▪ **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. These summaries appeared to be a verbatim reiteration of the assessment information. The individual had only lived at the Facility for approximately a year and a half, so LBSSLC had little historical information to share. ▪ **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 would be sent to the receiving SSLC. It also indicated a copy of her full records would be sent to the receiving SSLC at the time of her transfer. ▪ **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 her new settings. For Individual #57, the discussion included specific supports, and also referenced some important preferences to make the transition easier. Due to the importance of the implementation of her PBSP, LBSSLC were scheduled to provide training to receiving staff. It was also positive that the psychiatrists from both Facilities shared information during the discharge meeting. 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.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o LBSSLC Guardianship Process policy, revised 10/17/12; o DADS Policy Number 019 on Guardianship, effective 3/7/12; o Prioritized List of Those in Need of and Legally Authorized Representative (LAR), revised 3/19/13; o Prioritized List of Those in Need of and Legally Authorized Representative (LAR), revised 6/17/13; o New Guardians Since 10/1/12; o Contact Log regarding guardianship from 10/9/12 through 5/24/13; o Department and QA Meeting minutes, dates 1/15/13, 2/12/13, 3/19/13, 4/16/13, and 5/15/13; o QA/QI Quarterly Summary, dated 4/25/13; o List of staff who attended training on supports versus restrictions; o Presentation Book for Section U; o Self-Assessment for Section U, updated 6/20/13; o Action Plans: Section U, undated; 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 6/20/13. 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: ▪ The Facility used a monitoring tool. It was entitled: Settlement Agreement Cross Referenced with ICF-MR Standards – Section U: Consent.

	o Because a functional capacity assessment tool or process had not been established, implementation of this tool was minimal. In other words, there was little that could be assessed. However, the Self-Assessment did not include all of the necessary indicators. For example, there was no mention of whether or not teams were correctly prioritizing individuals' need for guardianship, or whether teams and/or the Facility were making reasonable efforts to obtain guardians for individuals assessed to need them. o The QA Department selected a sample of eight records from the list of individuals on the prioritization list (i.e., all those individuals without guardians), resulting in approximately a 30% quarterly sample. This appeared to be a representative sample. o Although the Self-Assessment included percent sample sizes, the numbers did not consistently make sense, and were not necessarily consistent with the sampling methodology described (e.g., for Section U.1, sample sizes of 20 out of 20, and six out of 95, presumably all for ISP monitoring) o The staff responsible for this tool were the Human Rights Officer/Guardianship Coordinator and a Program Compliance Monitor assigned from the QA Department. o They had worked to establish inter-rater reliability, and it was estimated to be above 90%. However, as noted above, little was available to monitor, so once a functional capacity assessment/process is defined, it will be important to ensure these high rates of inter-rater reliability continue. ▪ 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. ▪ 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. However, the Facility provided copies of the minutes from monthly meetings between the Human Rights Officer and the PCM. During these meetings, staff discussed barriers to complying with the Settlement Agreement requirements, as well as actions taken to overcome some of the barriers. The Action Plans submitted for the Settlement Agreement Section U also provided a reasonable approach to addressing the issues that were within the Facility's control. 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: As previously reported, the State Office Guardianship Policy had

	been disseminated, but the policy on consent remained in the development phase. LBSSLC had adopted the State Office Guardianship policy and had begun to implement portions of the policy. The Facility also had individualized the policy some to reflect its internal processes. Since the last review, the Facility had developed a Guardianship Committee and it had begun to meet. The Committee included mostly Facility staff, but one community member was on the Committee, and the Human Rights Officer was working on identifying additional community members. The Facility staff selected for the Committee had a variety of experience and expertise that should be helpful in completing the duties of the Committee. One of the major responsibilities of the Committee would be maintaining the priority list of individuals needing 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 or process. LBSSLC had begun to work with teams to identify current assessments that would assist in this process. They had identified some, but not all of the relevant assessments. In addition to identifying the specific tests or components of assessments that would need to be considered, a standardized tool/process would need to take into account assessment of whether or not alternatives to guardianship would be a viable less restrictive option. 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 6/17/13, included names of 75 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 36% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 35 individuals had a Priority I need for guardianship, 34 individuals were in the Priority II category, and six 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 resulted in guardians being appointed for 11 individuals, with another seven individuals in some phase of the process. However, it is important to note that this was being done without a good assessment to even determine who might need a guardian, and who could make some or all decisions with other less restrictive alternatives to support them. That being said, for individuals who did lack the functional capacity to make decisions, but who did not have family or other interested parties involved, it remained unclear what, if any guardianship resources were available. Although some Facility staff had been appointed or were pursuing guardianship for individuals at LBSSLC, the potential conflicts of interest this presented were discussed with Facility and State Office staff.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	As previously reported, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. LBSSLC had adopted the State Office Guardianship policy and had begun to implement portions of the policy. The Facility also had individualized the policy some to reflect its internal processes. Since the last review, the Facility had developed a Guardianship Committee. The Committee included mostly Facility staff, but one community member was on the Committee, and the Human Rights Officer was working on identifying additional community members. It was clear from documentation provided that efforts had been made to contact a number of community members to ask them to participate on the Committee. The Facility staff selected for the Committee had a variety of experience and expertise that should be helpful in completing the duties of the Committee. For example, a staff member who had experience with adoptions and guardianship, the Admissions and Placement Coordinator, and a Residential Coordinator that had worked at the Facility for 20 years were all Committee members. On April 10, 2013, the Committee had its first meeting. One of the major responsibilities of the Committee was maintaining the priority list of individuals needing guardians. At the first meeting, the Committee members reviewed the list and removed names of individuals that had moved to the community or died. 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. One indicator of this was that according to staff, all individuals currently without guardians were on the prioritized list. It was unlikely that all individuals at the Facility needed guardians. As reported previously, 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. During this most recent review, Facility staff indicated that they had looked more at the types of assessments already completed, such as psychology and psychiatry, as well as gathering information from staff that know the individual best, as mechanisms for conducting the functional assessment the Settlement Agreement requires. These would certainly be assessments that should be considered. As the Monitoring Team	Noncompliance

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		indicated another essential assessment in this process would be the Speech and Language evaluation, because in addition to determining a person's cognitive ability to make informed decisions, the ability to communicate such decisions is also a factor. The complicating factor would be for individuals for whom it is not immediately clear from these assessments whether or not they have the functional capacity to make decisions. Further assessment might be necessary to determine the types of supports that could be put in place to assist individuals to make decisions. One of many factors would be the use of assistive devices to help a person communicate his/her decisions. Given the complexity of such an assessment, the Facility should continue to coordinate its efforts with other Facilities and State Office. The Facility provided some examples of Rights Assessments that documented the teams' review of the psychological assessments as well as the Functional Skills Assessments to provide justification for the teams' decisions regarding individuals' decision-making capacity. As discussed while on site, these descriptions did not specify the test results or specific portions of the assessments that spoke to decision-making capacity. Also missing was any assessment of communication skills as well as any review of less restrictive alternatives that could prevent the need for guardianship. Facility staff indicated they planned to conduct more training with IDTs in coming months. Although the Guardianship 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. 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. 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.	

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		As discussed in the last report, 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 6/17/13, included names of 75 individuals served by LBSSLC. At the time of the review, Lubbock supported 211 individuals, of whom approximately 36% were estimated to need guardians. Although it was unclear how individuals' lack of capacity to make decisions had been determined, based on the list, 35 individuals had a Priority I need for guardianship, 34 individuals were in the Priority II category, and six were in the Priority III category. As part of its action plans, the Facility was planning to identify other supports that might assist individuals to make decisions. As indicated in previous reports, these should 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.). 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	

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		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. The Facility remained out of compliance with this provision of the Settlement Agreement. However, LBSSLC had made some progress in finalizing a local policy on Guardianship, re-developing a Guardianship Committee, as well as beginning to work with teams on identifying existing assessment information that could be part of a larger effort to assess functional capacity.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	According to documentation and interview with staff, since 10/1/12, 11 individuals had guardians appointed. At the time of the review, potential guardians were in some stage of the process of petitioning the court for guardianship for an additional seven individuals, and guardianship information packets had been sent to 12 interested parties. As noted above, the list the Facility provided showed that a total of 75 individuals of the 211 individuals served by the Facility (36%) 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. During the current review, Facility staff also reported that they planned to meet with a local for-profit guardianship agency to determine if their services might be appropriate for individuals at LBSSLC, as well as work on developing a user-friendly guide on guardianship, and draft blurbs for inclusion in newspapers. Staff also continued to attend guardianship training in the local area to maintain and expand their contacts. The Human Rights Officer/Guardianship Coordinator had provided training to QDDPs during which the QDDPs' role in assisting to identify and educate family members or other involved persons about guardianship was discussed. One concern that arose during the review was the use of Facility staff as a resource for guardians for individuals LBSSLC supported. In one instance, staff had been appointed as an individual's guardian, and a couple more were pending. Although staff reported that care was being taken to ensure that these were not staff working directly with individuals, a conflict potentially still existed, given that all staff at the Facility ultimately reported to the Facility Director and worked for DADS. As a result, their decision-making	Noncompliance

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		could be impacted by their employment status. This issue was discussed with State Office staff, and it is the Monitor's understanding that since the onsite review, further discussions have occurred regarding the these potential conflicts. As noted in the Monitoring Team's previous reports, 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. A subcommittee of the Family Association reviewed and approved 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. This in conjunction with the Family Association's fund helped defray the costs of petitioning for guardianship. LBSSLC was not in compliance with this provision of the Settlement Agreement. Facility staff continued to take actions to identify guardians for individuals for individuals with interested families or other interested persons, but not necessarily based on prioritized need or even an assessed need for guardianship. In addition, although the Facility was trying to identify guardianship resources for individuals without involved family, given that the Facility estimated that many additional individuals required guardians, these efforts were not adequate. As has been discussed in previous reports, identifying guardianship resources likely will need to involve collaboration between DADS State Office and the State Supported Living Centers.	

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 Policies: ▪ Recordkeeping, revised 8/20/10; ▪ Individual Notebook, dated 2/24/11; ▪ Record Monitoring Guidelines, dated 5/13/11; ▪ Section V: Recordkeeping and General Plan Implementation, Provisions 1, 2, 3, and 4, dated 12/2/10; ▪ Active Record Check Out/Check In Process, dated 6/11/11; and ▪ 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 5/23/13; o Quality Assurance checklists for last 10 records reviewed, various dates; o In response to request for plan of correction resulting from record audits, the following statements: "No Plans of Correction done from Record Audits for last three months" and "No Plans of Correction done for Timely Submission of Documents for last three months;" 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 In response to request for follow-up to confirm results of corrective action, the following statement: "Continuation of Recordkeeping Practices Corrective Action and Follow up with Random Quiz Training and Retraining of Recordkeeping Practices;" o Sample Recordkeeping quizzes, various dates; o List of new or revised Facility procedures since 9/21/12; o List of SSLC Policies, dated 6/3/13; o Emails related to training on policies, various dates; o Exception reports for training on policies, various dates; o QA Monitoring for last six months; o Description of action taken to address issue Monitoring Team identified with regard to filing of acute care plans; 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 6/20/13. 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. For example, the Unified Records Coordinator recently had begun to attend ISP Preparation and ISP meetings to better assess the Section V.4 requirements related to the use of the records in decision-making related to individuals treatment. o The monitoring tools did not yet include adequate methodologies. Although as noted 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). As previously discussed, if other disciplines were collecting such information, it could be used to assess the requirements of Section V. o The Self-Assessment identified the sample(s) sizes. It now 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). 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 was responsible for completing the audit tools: the Unified Records Coordinator. The Lead File Clerk no longer regularly conducted the reviews, but was available as a back-up auditor. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although 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 Inter-rater reliability had been established between the Unified Records Coordinator and the Lead File Clerk. ▪ The Facility used 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.

	▪ 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: According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. The Facility recognized that a next step was addressing some of the issues that monitoring showed with regard to the requirements of Appendix D of the Settlement Agreement, including issues related to the quality of the records. Since the last review, 27 procedures were developed or revised, and training had been completed on 20 of the 27. Training was in process for the remaining, more recently issued procedures. Since the last review, the Competency Training Department had developed and implemented a system to track the completion of training on each of the new/revised policies. Reports showing which staff had completed the training were submitted. Email correspondence documented when the staff requiring training had completed the training. This represented significant progress since the last review. 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 a number of problems with the records. The Facility recognized that the next step would be aggregating and analyzing information gained through record audits in more depth to determine if specific corrective action was needed. Using monitoring data, the Facility also had recently taken action to address issues related to checking records out and in whenever they were removed from the residences. It was positive that the Facility was using data in this way, and that the Facility recognized the need to do deeper analysis of other data it was collecting. 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.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the	As noted in previous reports, a review of the LBSSLC policy on recordkeeping, revised in August 2010, revealed that it was consistent with the DADS policy on recordkeeping, 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	Noncompliance

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	guidelines in Appendix D.	Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. State Office had issued a revised Table of Contents for the Active Records. The Facility Director had made the decision to defer implementation until after the Monitoring Team's review. The Facility had a plan for beginning the conversion starting on 7/22/13. In June 2013, action plans from ISPs were added to Individual Notebooks. This included a process of confirming these changes had been made. ▪ 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. ▪ Since March 2012, the Unified Records Coordinator had continued to provide an hour-long training session as part of New Employee Orientation. As noted in previous reports, 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 Record, dated 8/11/11. The Facility reviewed 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. ▪ During the last review, 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 one department with many documents requiring submission. Reportedly, at times, this delayed the submission of important documents for filing. After the Monitoring Team's review, the QA Department staff worked out a solution whereby the Medical Records Clerk entered the documents for the Medical Department into the tracking sheets. This reportedly had solved the problem. ▪ When monitoring indicated problems with staff's adherence to the check-out/check-in process, the Facility took action to correct this potential security issue. Specifically, in March 2013, the QA Director sent an email to all staff reminding them of the rules. The ADOP followed up with an email reinforcing	

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		the need for staff to adhere to the procedures established for signing out and in the records. ▪ When the Monitoring Team identified an issue with regard to the timely filing of acute care nursing/health care plans, the QA Director immediately worked with the Nursing Department to develop, train on, and implement a solution. Due to the nature of the plans, there was a need for the acute care plans to be filed immediately, as opposed to going through the typical filing process that took approximately three days. The resolution that was put in place was that during business hours on weekdays, the RN Case Managers would contact the file clerks who would file the plans immediately. During other hours, the nurse writing the plan would file the plans. The responsiveness to this issue was noteworthy. Areas in which improvements should be made in order to achieve compliance, included: ▪ As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. This is discussed in further detail with regard to Section V.3. Facility staff indicated that the next steps were to determine what 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 Team recognizes that this should be done in the least cumbersome, and most normative fashion. Although changes were being made, it remained to be seen if LBSSLC's methodologies would address fully the requirements of the Settlement Agreement. The State Office should provide additional guidance on this issue. While the Facility had continued to make progress with regard to the quality of the active records, it was not yet in compliance with this provision of the Settlement Agreement.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof	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	Noncompliance

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	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.	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: ▪ In April 2013, the policy on Developing/Revising Policy or Procedures was updated. ▪ 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, 27 procedures were developed or revised since the previous compliance review. The OPM Committee had reviewed and approved with revisions 27 of them. Training had been completed on 20 of the 27. Training was in process for the remaining, more recently issued procedures. ▪ The OPM Review Committee was now 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. ▪ Based on a review of the correspondence sent regarding new or revised policies, 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. ▪ Since the last review, the Competency Training Department had developed and implemented a system to track the completion of training on each of the new/revised policies. Reports showing which staff had completed the training were submitted. Email correspondence documented when the staff requiring training had completed the training. This represented significant progress since the last review. 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 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. The Facility should continue to develop and revise policies in concert with the issuance of State Office policies.	

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V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ Based on documentation submitted, it appeared the Unified Records Coordinator was completing at least five record audits per month. After the last review, the Facility moved forward with plans to establish inter-rater reliability between the Unified Records Coordinator and Lead File Clerk. The Lead File Clerk then stopped completing regular reviews of records, but was available as a back-up auditor. ▪ 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. This data was then graphed by question on the tool. Based on review of data for March and April 2013, consistent problems were seen in such areas as the completeness, accuracy, and currency of information in the records. ▪ In addition, starting in June 2011, one individual's team was selected each month for completion of the State Office's interview tool designed to solicit information specifically about Section V.4, which requires the Facility to routinely utilize individuals' records in making care, medical treatment, and training decisions. Based on review of recent record reviews, the Unified Records Coordinator continued to complete these tools. ▪ The Facility also had determined that some additional monitoring was necessary. This included: o As noted above, 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 reinforce these requirements with staff, which was done in March 2013. o Monitoring was conducted 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, from February 2013 through April 2013, the data showed a 100% 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. ▪ The Facility also was working to identify a better process for the notifying staff	Noncompliance

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		to take specific corrective actions that were needed for individuals' files that were identified through regular record reviews. A process was in place, but the current form only allowed a certain number of charters to describe the issue. This was being supplemented with emails. ▪ Some corrective actions had been taken when issues were identified, such as: 1) when records were identified as missing, action was taken to find them, and to address the specific issues that had resulted in their being missing for a period of time; 2) as noted above, action had been taken in response to findings that the check-out/check-in process was not followed; and 3) when the Monitoring Team identified issues related to timely filing of medical documents and acute care plans, the Facility took action to correct the issues identified. 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 required correction. At the time of the Monitoring Team's review, some of the corrective actions had been completed in the recent past (e.g., reminding staff of the need to check-out/check-in records). Based on documents submitted prior to the review, the Facility indicated that it had not yet taken action to determine the effectiveness of the actions taken. ▪ 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. 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 On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 several Integrated Health Care Plans and Comprehensive Nursing Assessments were missing from the records. However, it was unclear if these documents were missing, had not yet been filed, or if the documents had not been completed. 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 Coordinator was asking a sample of team members to complete the questions that State Office had sent related to Section V.4. Review of a small sample of these completed forms generally showed that staff were able to articulate how they used the records. Based on discussions with Record Department staff, sometimes, team members included recommendations to improve the records. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** In April 2013, the LBSSLC Unified	

#	Provision	Assessment of Status	Compliance
		Records Coordinator had begun attending five ISP Preparation meetings per month, and then following these ISPs through to completion to determine if team members routinely used the record to make care, medical, treatment, and training decisions," as well as to assist in determining the accuracy of the information in the records. 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 at times, 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 some of the quality of data and information in the records was not adequate to allow teams to make well-informed decisions.	

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

CLIA	Clinical Laboratory Improvement Amendments
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
CPAP	Continuous Positive Airway Pressure
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
HMT	Health Monitoring Tools
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
PAD	Peripheral Artery Disease
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