United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

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Submitted By: Maria Laurence, MPA, Monitor

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

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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

In a number of areas, Lubbock State Supported Living Center (LBSSLC) was continuing to show good progress in its efforts to comply with the Settlement Agreement. As this report shows, in some areas, the Facility had gained substantial compliance findings, and in other areas continued progress had been made that should lead the Facility towards more substantial compliance findings during upcoming reviews. There were some areas in which little progress had been made, and these are certainly areas in which focused efforts are needed.

Based on the Monitor's discussion with the Facility Director as well as the Monitoring Team's interviews with other staff and review of documentation, it was clear that Facility staff were carefully reviewing the Monitoring Team's reports and reviewing the Facility's own self-assessment data, and then identifying areas to work on during the months in between reviews. This approach to specifically addressing the requirements of the Settlement Agreement was having a positive impact on some of the protections, supports, and services the Facility was providing to the individuals that live at the Center. Of particular note, the Facility's QA/QI Council, as well as the Executive Safety Committee, and groups such as the Mealtime Coordination Committee had begun to conduct more in-depth analyses of data, and this was assisting the Facility to identify problems, and then develop action plans to address them. As a result, many of the issues the Monitoring Team identified were not surprises to the Facility, and in many cases, the Facility had developed or discussed the need for plans of improvement. Such quality assurance processes are incredibly important for a good functioning system. The Monitoring Team encourages Facility staff to continue to use this thoughtful process as they continue to address areas requiring attention.

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:

<u>Restraints</u>

- Progress was noted in a number of areas. Highlights of progress included:
  - Trend reports not only tracked restraints over time, but that tracking information was compared with other data in the Executive Safety Committee to inform decision-making.
  - The Executive Safety Committee had developed into a valuable resource for reviewing, comparing, and making decisions based on a variety of data streams. Because it included the highest level of management, the Committee was well positioned to act based on the data analyses that it reviewed, and there was evidence that actions were being taken to create a safer environment for the individuals who resided at the Facility.
  - The timeliness of nurses responding to restraints had seen improvement since August.
  - Restraint use was being reviewed at Unit meetings, incident management meetings, and by interdisciplinary teams (IDTs) following most restraints, and new procedures were put in place to assure accurate documentation of the Incident Management Review Team's (IMRT's) reviews.

- The quality monitoring the Behavior Services Department and the Program Compliance Monitor served to identify and direct corrections to processes that helped bring this section closer to compliance with the Settlement Agreement.

- 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:
  - Achieve closure on the issue of orders for medical/dental restraints. The physicians' orders need to include the schedule and type of monitoring, and monitoring according to the prescribed schedule needs to occur and be evident in the restraint documentation.
  - After the onsite review, the Monitoring Team raised issues to the State Office surrounding timely medical treatment for individuals who might need the use of pre-treatment sedation to cooperate with dental or medical procedures. In response, State Office indicated that it subsequently had worked with the Facility to ensure that the answers to the legal questions that had been raised were communicated to medical staff, and individuals for whom delays in care had occurred received the care they needed. It will be essential going forward for follow-up to occur to ensure this issue has been resolved, and does not continue to impact individuals.
  - In addition, issues needed resolution around who might need desensitization efforts or other strategies to help them accept treatment without medications or restraints. It will be essential for careful review to occur of individuals receiving various forms of sedation (e.g., pre-treatment sedation, intravenous sedation, and general anesthesia) to determine who might benefit from plans to potentially reduce the need for such practices, and for such plans to be developed and implemented.

<u>Abuse, Neglect and Incident Management</u>

- LBSSLC was found to be in substantial compliance with all subsections of Section D.
- Highlights of progress included:
  - The Executive Safety Committee had made major progress in developing a working process for reviewing complex data streams and identifying trends, including issues and individuals in need of focused attention. The data presentations appeared comprehensive and useful, and the committee's efforts were demonstrating how data could drive decision-making.
  - Although the procedures required further refinement, the injury audit procedure was in place and producing useful information.
  - Recommendations were found in Department of Family and Protective Services (DFPS) reports and in Unusual Incident Reports (UIRs), as well as in the review check sheets the Director completed, and there was evidence to assure the recommendations had been addressed.
- The Facility had a system in place for reporting, and investigating possible abuse and neglect. However, as discussed with regard to the Facility Self-Assessment, the Facility did not yet have a self-assessment process that produced reliable and valid results, and looked at both the presence as well as quality of efforts to protect

individuals from harm. Going forward, the Facility will need to improve these efforts and be continuously vigilant with quality monitoring to ensure that the processes in place stay vigorous, and that there is consistent follow-up on recommendations from investigations to help prevent abuse and neglect from happening in the first place.

Quality Assurance

- Although it is not reflected in an increase in substantial compliance scores, since the Monitoring Team's last visit, the Facility had made some notable progress with regard to Section E, including:
  - The Executive Safety Committee had continued to review data on incidents, injuries, and restraints, and was 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. Data were analyzed by individual across multiple data sources to produce lists of those individuals with the most issues. This Committee was composed of executive staff, including the Quality Assurance Director. As a result, the Committee could direct immediate action toward solving problems and they did. When the actions taken did not resolve an issue, the issue was referred to the QA/QI Council for additional consideration and action.
  - Some key indicators of performance, called Administrative Outcome Measures, were in place, and data collection had begun in September 2013, with October 2013 data being considered the baseline.
  - The Monitoring Team noticed discussions about quality and about accuracy of data not only with regard to Section E, but also throughout the Facility, suggesting a Facility-wide investment in quality.
  - Revisions were made to the QA Plan that addressed issues identified during the last visit. Specifically, the matrix had been improved and appended, the data inventory had been established and appended, and key indicators of Facility performance had been appended.
  - The number and sophistication of CAPs had increased. For example, there was a CAP on peer-to-peer sexual incidents that included new approaches to teaching identified individuals about relationships and appropriate behavior in public, as well as security considerations. The CAP was cross-disciplinary and data driven, and it was an important, although not an easy issue to address.
  - Staff had been added to supplement data analysis, nursing quality assurance, and the administrative functions of the department.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - Much work was done on establishing key indicators of progress across the system, the Facility had begun to collect data on those indicators, and the data were included in the data inventory. However, definitions for key terms and methodologies for collecting the data need to be established. Benchmarks and goals for key indicators need to be established, and steps need to be put in place to assure that the data collected are accurate and reliable measures of progress. Over time, additional key indicators will

need to be added for a comprehensive list to exist. However, as the Facility had decided to do, it is important to start with a reasonable number, and build the system over time.
    - The matrix needs to be further updated and designed to facilitate accurate tracking of the names and numbers of monitoring tools and whether they have been used as anticipated.
    - While there was progress in the development of CAPs, more work was needed to encourage the development of CAPs that result from data analyses, and include baseline and outcome measures in measurable terms. Other than through the work of the Executive Safety Committee, strong analysis of data was largely lacking.
    - There was progress in some sections in avoiding reliance on single overall compliance scores. This progress needs to continue by drawing attention to the specific data that indicate a need for action or for CAPs.

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

- As noted in the last report, an Individual Support Plan (ISP) Workgroup had developed and begun to implement action plans to address a number of key elements of the ISP planning and implementation process. Based on this most recent review, these efforts continued to have a beneficial impact in a number of areas. The Workgroup had continued to meet with a smaller number of participants to allow focus on key issues. Some of the improvements that were noted with the ISP process included:
    - Although issues continued to exist with regard to teams accurately identifying the need for team members' participation in ISP meetings, attendance of members that the teams had identified as "required" had continued to improve. The Facility's data showed where some of the problems were, and some efforts were underway to improve these team members' attendance. For example, the Facility was in the process of implementing a CAP to improve the attendance of individuals, their guardians, and direct support professionals.
    - ISP meetings were generally being held annually, and individuals newly-admitted to the Facility were having ISP meetings within 30 days of their admission. In addition, in recent months, final ISP documents were being completed within 30 days of the meetings.
    - The Facility had made progress in its efforts to develop and implement a system to train staff on the necessary components of the ISPs, and track this training.
- Some of the areas in which focused efforts continued to be needed included:
    - The Facility recognized that the quality of assessments was an area needing improvement. The ISP Workgroup was in the process of developing a quality check system for the ISP assessments. At the time of the onsite review, discipline leads had been assigned the task of individualizing the Assessment Quality Checklist for their assessments. It was anticipated that once the audit forms were finalized, discipline leads would review the assessments for a sample of five records each month.

- Since the last review, the Qualified Intellectual Disability Professional (QIDP) Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that nine out of 15 QIDPs had been deemed competent using this tool, with one QIDP identified as "needs work," four that had not been assessed, and one vacancy. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation.
- 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.
- The Facility was using the Integrated Health Care Plan (IHCP) format, which often expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences.
- Action plans included more measurable action steps, which was positive, but this was an area in which work was still needed. Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, behavior, skills, etc., or maintaining his/her current status).
- The Facility recognized this was an area needing improvement, but the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy.

<u>Integrated Clinical Services</u>

- For Section G, the Facility continued to demonstrate implementation of a number of structures to assist in ensuring that individuals received needed services. The provider morning meeting tracked change of health status concerns as defined through hospitalizations and Emergency Room (ER) visits. Clinical care of those hospitalized was assessed by completion of open record reviews and discussion of findings, as well as post-hospital ISPA creation. The provider morning meeting provided the quality review of the content of the ISPA for individuals that experienced hospitalizations and ER visits, and ensured appropriate acute care and preventive steps were in place. Other closure concerns of various clinical areas that the group identified also were tracked to closure. Written documentation was required for closure to occur. Attendance also was tracked to ensure that all clinical disciplines were represented. A formal agenda was followed that allowed for weekly reports from other clinical disciplines, such as Laboratory, and Dietary Departments.
- The Facility had made progress with regard to the provision of integrated care, particularly through its provider morning meeting processes. Some other forums also showed commitment to integrating clinical supports, such as the Physical and Nutritional Management Team (PNMT), the quarterly psychiatric clinics, and effort to address an infectious outbreak on campus. However, there were still a number of areas where this integration was not apparent, and work was still needed. Some examples of areas where clinical integration had not yet matured were the development and implementation of IHCPs for at-risk individuals as part of the annual ISP

process, efforts related to reducing the need for pre-treatment sedation, and attendance of necessary clinical staff at ISP meetings, particularly dental and pharmacy staff.

- Significant consults also were reviewed during the provider morning meeting. There was also tracking of consult reports to determine review by the Primary Care Practitioner (PCP) and appropriate implementation of recommendations.

Minimum Common Elements of Clinical Care

- LBSSLC continued to demonstrate progress with regard to Section H. The morning meetings provided oversight to acute change of health status concerns for individuals that were hospitalized or had gone to the Emergency Room.
- There was an internal medical quality improvement system, which included the completion of many audits. The audits provided oversight to maintenance of quality and standards of care. Numerous clinical indicators were included in the audits, and results were available for each of these. Additionally, the medical provider quality assurance audits and medical management audits, along with the provider morning meetings, provided monitoring of health care.
- However, the Facility's current practices largely related to the implementation of clinical guidelines that indicated which steps should be taken in the assessment/evaluation and order process, and did not provide a method for assessing whether or not treatments and interventions were provided as prescribed, and if so, if they had the intended effect. It will be important for the system to mature to a point where, using clinical indicators, the efficacy of treatment is reviewed for individuals as well as on a more systemic level, and that this information is used to make changes or take corrective action, when issues are identified. For example, the internal quality review should demonstrate monitoring of response to abnormal physical findings and lab/test results to determine timely and appropriate response by the PCPs. In addition, the at-risk system should continue to mature into a quality process, which demonstrates the full spectrum of health monitoring. It will be essential for the Facility's system to include indicators across all clinical disciplines, and not just those the Medical Department typically monitors.

At-Risk Individuals

- Since the last review, the At-Risk Individuals procedure was revised and finalized. The Facility's Self–Assessment indicated that a review of the training data for the Individual Support Plan – At-Risk Individuals procedure demonstrated that of the 425 staff identified as needing training, 365 staff (86%) received the training. In addition, any newly hired QIDPs were to be trained within the first 30 days of hire.
- On a very positive note, since the last review, the Facility had begun using Incident Management data regarding falls and restraint use when evaluating the accuracy of the risk ratings for falls and challenging behaviors. The Assistant Director of Programs (ADOP) reported that in reviewing this information, several individuals with high restraint use or high numbers of falls, some which resulted in injuries, actually had lower risk ratings than

appropriate. For these cases, special reviews of the risk levels were requested from the IDTs resulting in appropriate increases in the risk ratings.

- 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.
- Much of the Facility's data were promising, in that a standard presentation format appeared to have been established, and relevant information were included, such as the percent sample sizes. In addition, most of the indicators the Facility used since the last review were in alignment with the requirements of the Settlement Agreement, especially initial efforts made to address the quality of the teams' identification of needed assessments, the completion of assessments, and the related documentation. However, considerable more work was needed to address the quality of the documentation, and additional information should be provided regarding what specific criteria were used to determine compliance regarding the quality of the at-risk documentation.

Psychiatric Care and Services

- The Facility continued to employ two full-time Psychiatrists who shared the responsibility for providing direct psychiatric services to the 123 individuals prescribed psychoactive medication at LBSSLC. In addition, the Facility contracted with a part-time Consulting Psychiatrist, whose time was primarily devoted to updating the Comprehensive Psychiatric Assessments (CPAs) and performing second-opinion consultations for the two full-time Psychiatrists, on an as needed basis. Since the last review, a Psychiatric Assistant and Psychiatric Clerk had left LBSSLC. However, the Department had been able to hire a full-time Psychiatric Nurse, who had assumed many of these responsibilities. The Psychiatric Assistant position remained open.
- The Facility's internal data indicated that they continued to update the CPAs on an annual basis for 100 percent of those individuals prescribed psychotropic medication, and the current review of the records of 15 percent of those individuals prescribed psychotropic medication was consistent with this finding. The quality of the content of these documents also remained consistent with the requirements of the Settlement Agreement. The initiative for the Psychiatrists to attend all of the ISPs for the individuals they served also had continued, and internal documentation indicated an attendance rate of 95 percent. The review conducted of the sample of individual records found an attendance rate of 90 percent for a slightly different time period. This review also found that the Psychiatry Department submitted the Psychotropic Medication Treatment Plan (PMTP) to the Interdisciplinary Team (IDT) at least ten days before an individual's annual ISP at a rate of 97 percent, as based on an expanded review of 24 percent of the final ISP documentation and related PMTPs. However, as will be discussed in the report that follows, there had been deterioration in the content of both the narrative sections of the ISP and the Integrated Risk Rating Form (IRRF).

- The progress in reducing and carefully reviewing the number of individuals, who were prescribed psychotropic medications that constituted polypharmacy, also had continued. The rate of active polypharmacy had increased somewhat. This was primarily due to individuals who had been admitted in recent years from the community on polypharmacy, but who had resided at LBSSLC longer than one year, migrating from the New Admission category to the Active category. In addition, changes in the clinical status of some individuals, who had been stable, led to their also being moved to the Active category. One would expect the rates of polypharmacy to fluctuate somewhat over time, but the rates at LBSSLC remained low, and the teams were making active efforts to challenge and reduce polypharmacy, when appropriate.

Psychological Care and Services

- Since the Monitoring Team's last review, progress by Behavioral Health Specialists in their pursuit of certification as Board Certified Behavior Analysts (BCBAs) continued. In addition, the Facility continued to maintain an effective internal and external peer review system.
- The methods used for data collection, including data collected with regard to inter-observer agreement (IOA) and competency-integrity, as well as ongoing monitoring and review continued to reflect improvement. However, progress still was needed with regard to ensuring the adequacy of monthly PBSP notes.
- Efforts to improve the quality of functional assessments were noted. However, a substantial number of individuals with PBSPs did not have the benefit of these improved assessments.
- Although progress was evident in adhering to the new Behavioral Health Assessment form, the Monitoring Team found no evidence of progress in updating standardized tests of intelligence and adaptive behavior. Consequently, a substantial number of assessments continued to include testing data that was outdated.
- Efforts at developing more effective counseling supports were evident.
- Progress in the development of quality PBSPs continued to be noted. However, concerns with regard to the quality of operational definitions for replacement behaviors and adequate behavioral objectives for target and replacement behaviors remained.
- The Facility was successful in maintaining progress in ensuring that PBSPs were written so that direct support professionals could understand them effectively.
- Efforts to enhance the provision of New Employee Orientation (NEO) and On-the-Job Training (OJT) to new hires were noted, and the Facility appeared to conduct competency-based training for staff on the majority of PBSPs. In addition, the Facility recently initiated a system to track and monitor those who had successfully completed CBT on PBSPs as well as other programming, which is a necessary component of the training program.

Medical Care

- For Section L, progress was evident in all subsections. Strengths in Section L included preventive care, with completion of screening procedures in a timely manner, such as colonoscopies, pap smears, and DEXA scans. The Medical Department demonstrated prompt and thorough monitoring and follow-through of all acute care issues at the provider morning meeting. Appointments were tracked until completion of the visit. There were

numerous quality indicator-monitoring tools created for specific diagnoses. Audit results were available. The Facility conducted analysis of results of various audits, completed in-service training, and conducted further audits to determine impact of the training. Follow-up on recommendations from the mortality review process appeared to be occurring, and closure of recommendations was now tracked.

- There were several challenges. The quality and timeliness of the annual medical assessments required further review, as well as the quality of the quarterly medical reviews. The internal quality improvement would benefit from focus on areas that remain challenging (e.g., evaluations of specific signs or symptoms such as respiratory distress, and monitoring of response to abnormal lab results). The medical manual required further development to reflect an ongoing review process.

<u>Nursing Care</u>

- 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 some turnover in the key nursing leadership positions. Due to these staffing issues, the Facility had to continue to use Agency nurses to cover many of the vacant positions, and continued to do so at the time of the review. In addition, the turnover had resulted in a number of promising systems that previously had been implemented not being maintained, because none of the new nursing leadership staff had any overlap with their predecessors. However, some of the Facility's positive steps forward included:
  - The data indicated that of all of the 111 (100%) total emergency drills that were conducted were deemed as passing, which was a very positive finding.
  - The Monitoring Team's review of the Facility's data verified that the required daily emergency equipment checks Risk Management staff and nursing staff completed were consistently being conducted.
  - The Facility took aggressive action to address an ongoing outbreak of Clostridium difficile (C-Diff) that had not been adequately identified and systematically addressed for several months. The Facility had put together a very comprehensive Presentation Book that included specific and detailed information regarding what actions were taken both on a systemic level as well as on an individual level. In addition, the Facility brought in an Infectious Disease physician who provided clinical expertise to the Facility regarding isolation strategies as well as treatment recommendations. Facility staff's presentation of this issue to the Monitoring Team at the beginning of the review week demonstrated that the Facility had taken an integrated approach to a very challenging and serious health issue that ultimately benefited the individuals as well as the staff at the Facility. While 19 individuals were involved in the outbreak, at the time of the review, no individuals were experiencing symptoms of C-diff.
  - On a very positive note, regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 19 individuals had had an incident of an acute infection: C-Diff. Of the 19 incidents, all individuals (100%) were found to have had Care Plans

addressing the infectious issue. Of the 19 Nursing Care Plans reviewed, 16 were found to be clinically adequate (84%).
    - The pharmacy continued to conduct spot checks audits of the Medication Administration Records and the medication rooms across all the residences.
- Although the Facility had made some positive steps forward in the areas noted above, there continued to be an overall lack of progress, and in some areas, significant regression, found regarding the infection control program, the integrated health care plans, the nursing assessments, documentation in response to changes in status, and the quality of the quarterly and annual Comprehensive Nursing Assessments. Unfortunately, the challenges in stabilizing the nursing coverage related to staff turnover had continued from the last review, and the significant changes made in the nursing leadership positions since the last review had prohibited the Facility from making progress in many of the crucial areas affecting individuals' healthcare.

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

- The Pharmacy Department continued to complete the Quarterly Drug Regimen Reviews (QDRRs) and the PCPs and the Psychiatry Department processed them in a timely manner. The chemical restraint forms were completed in a timely manner, and included quality information.
- The Pharmacy tracked the in-service training on Adverse Drug Reactions (ADRs). Currently, all new hires received a basic course in health status change, which also applied to adverse drug reactions. Additionally, new nurses completed an ADR reporting course. The Pharmacy provided annual refresher training to the medical, pharmacy, and nursing staff. All of this training for ADRs appeared to be complete.
- Medication variances continued to be a challenge. The Pharmacy developed an additional internal audit process to track medication variances that occurred prior to dispensing the medication. Additionally, there were continuing efforts to assist nursing staff to reduce the numbers of excess unknown returned medications. However, this continued to be an area of significant challenge.

<u>Physical and Nutritional Supports</u>

- At the time of the Monitoring Team's review, the Facility had policies, protocols, and guidelines related to physical and nutritional supports that incorporated necessary elements; the Physical and Nutritional Management Team (PNMT) had the required core members as outlined in the Settlement Agreement; PNMT members had exceeded the annual requirements for continuing education, and the continuing education completed was relevant to the physical and nutritional supports and transferrable to the population served; the PNMT was consulting with medical providers and IDT members in a variety of ways; the PNMT was meeting on a regular basis; and the PNMT had established a system to resolve identified systems issues. The Facility was found to be in substantial compliance with Section O.1.
- The Facility had a sustainable system to maintain and update lists identifying each individual who physical and nutritional management (PNM) needs. On 10/1/13, a PNMT referral form was implemented, which had increased the number of individuals referred to the PNMT. However, some individuals in the Monitoring Team's

sample should have been referred to the PNMT, but were not. The PNMT assessments and action plans included many of the necessary components. Additional work needed to be done to integrate PNMT recommendations into IHCPs.

- Physical and Nutritional Management Plans (PNMPs) had continued to improve, and contained most of the necessary components. In addition, the mealtime observations completed during this review were a significant improvement from the last review, at which time none of the mealtime observations showed that staff were adhering to individuals' dining plans. During this review, observations showed over 80 percent adherence to the dining plans, and prior to the review, the Facility had identified residences in which problems were occurring, and corrective action plans already were in place. The Facility is to be commended for their commitment in continuing to revise their Mealtime Coordination system to achieve the outcome of ensuring staff do not engage in unsafe mealtime practices and striving to support a mealtime environment that supports independence for individuals. The Facility was found to be in substantial compliance with Section O.4.
- The Facility had implemented a comprehensive PNM foundational training program for new employees and veteran staff. In September 2013, a mandatory PNM foundational annual refresher training had been initiated. The Facility therapists had identified 28 individuals who required PNMP individual-specific training. There was a sustainable system developed and implemented for the provision of individual-specific training for staff. The Facility was found to be in substantial compliance with Section O.5.
- The Facility had developed and implemented a PNM monitoring policy with operational guidelines, including the necessary components. However, PNMP monitoring was not occurring at the established frequency for individuals with high and/or medium PNM risks.
- The Facility had developed a protocol to define the system for effectiveness monitoring. An effectiveness monitoring tool had been developed, and therapists were implementing it on a trial basis for a few individuals on their caseloads. The tool was to be re-evaluated after this trial and revisions would be made, if necessary.
- The Facility had a sustainable system for identifying individuals who received enteral nourishment. Teams were not yet conducting integrated assessments and/or having and documenting discussions regarding plans for any modification of intake. The Facility had developed a protocol to define the process for determining whether an individual should return to oral eating and/or receive enteral nourishment in a less restrictive manner, and if so, the pathways for accomplishing these goals. This protocol also identified what the therapist and/or dietician would discuss with IDT members upon completion of their respective assessments. The implementation of this protocol should assist the Facility in moving in the direction of reaching substantial compliance.

<u>Physical and Occupational Therapy</u>

- The four individuals who were recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Individuals' OT/PT assessments included many of the assessment elements, however, essential elements continued to be missing. Individuals who had experienced a change in status either did not

have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements.

- Three of four individuals reviewed who were receiving direct OT and/or PT interventions did not have therapy plans. Monthly progress notes had not been consistently completed, and did not include the necessary elements. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs.
- Competency-based training for the implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with Section P.3. The Facility was in substantial compliance with Section O.5 and, therefore, Section P.3.
- The Facility had OT/PT policies/protocols that included the necessary elements. A protocol had been developed and implemented that described the system for monitoring individuals' assistive equipment. PNMP Coordinators were monitoring individuals' assistive equipment on a daily basis for availability (i.e., presence), cleanliness, condition, need for repairs, and need to replace (i.e., due to condition, not available). Direct support professionals also were responsible for monitoring individuals' assistive equipment daily for use and wear, and reporting to HT staff if any repair and/or replacement were needed. Review of a sample of individuals showed timely replacement or repair of individuals' assistive equipment. The Facility still had work to do to monitor the implementation and effectiveness of individuals' OT and PT supports.

Dental Services

- The Dental Department continued to have significant challenges. A number of annual dental assessments remained overdue. Additionally, the quality of the dental assessments improvements in such areas as adequate treatment plans and adequate descriptions of the behaviors of the individuals.
- Tracking periodontal disease did not appear to be a priority of the Dental Department. Even for those undergoing general anesthesia, completion of a periodontal chart or periodontal probe results were often lacking.
- From the information the Facility provided, the majority of individuals (estimated at 75%) were to undergo general anesthesia routinely for preventive cleaning, because, according to the Director of the Dental Department, the severity of periodontal disease required general anesthesia for cleaning to occur. From the review of a sample of individuals undergoing general anesthesia, there was no plan in place to reduce the severity of periodontitis in those who had a cleaning under general anesthesia, but plans were in place for continued periodic cleaning under general anesthesia. In the dental assessments, there was no mention of a SAP or other dental desensitization or behavior plan to improve cooperation, or if one were in place, a summary of the results, and/or related recommendations. The lack of programming to improve compliance in tooth brushing, oral hygiene exams, and cleaning indicated a failure to provide basic preventative dental care and services to this population. In this population, prevention likely would have the most impact on dental health. There were only a few individuals for whom a desensitization program or other strategies to reduce the need for

sedation were in effect. All individuals with moderate to severe periodontitis should have had a desensitization/behavioral program with continuous monitoring, service objectives for staff to assist with brushing their teeth, and/or a plan for the Dental Department to teach staff and individuals better tooth brushing skills, with training occurring both in the residence and in the dental chair.

- On a positive note, for those individuals with significant dental disease, who also had severe, comorbid medical conditions, an arrangement was made to have dental care provided at a local area hospital. This increased monitoring and the additional expertise available had proved successful in treating these individuals with medical complexities that were at high risk for complications during dental procedures/general anesthesia.

Communication

- The Facility had established a protocol that memorialized the process for determining Speech Language Pathologist (SLP) caseloads. At the time of the review, there were an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. The SLPs were licensed to practice in the state of Texas and provided evidence of current American Speech-Language and Hearing Association (ASHA) certification. SLPs had completed continuing education directly related to communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components. The Facility was found to be in substantial compliance with Section R.1.
- Individuals who had been newly admitted to LBSSLC had a SLP assessment completed within 30 days, SLP/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions. The Facility was found to be in substantial compliance with Section R.2.
- ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' AAC systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives.
- Individual-specific staff training and performance check-offs had been developed and implemented for one individual with an AAC system in the sample.
- Although a policy had been developed, further work was needed to implement monitoring of the provision of communication supports, as well as the efficacy of the supports.

Habilitation, Training, Education, and Skill Acquisition Programs

- Continued efforts to support the development of quality Skill Acquisition Plans (SAPs) were noted. This included stronger support for SAP developers from the State Office, the revision of the SAP development curriculum and the quality assessment tool, and improved ongoing monitoring of SAP quality. However, concerns remained regarding the quality of SAPs, including those targeting dental and medical desensitization,

as well as ongoing data collection, monitoring, and review. Overall, the SAPs reviewed, as well as data collection methods, and ongoing monitoring continued to demonstrate the need for substantial improvement.

- Estimates of engagement were improved compared to previously estimated levels. Concerns remained with regard to QA and Active Treatment staff continuing to estimate engagement using two different tools, as well as with the implementation of the SAP Integrity Monitoring Tool. Overall, slight improvement in providing opportunities for community outings were noted.
- Efforts directed at supporting day and vocational programming, including attendance, were noted. However, efforts at improving attendance at day program as well as on-campus and community-based employment had not yet evidenced substantial progress. The Monitoring Team strongly encourages the Facility to "raise the bar" for attendance at day programs and consider challenging IDTs to provide rationales for any individual that does not participate for the majority of the day.
- Efforts directed at improving tools to ensure the adequacy of annual assessments [e.g., the Preference and Strengths Inventory (PSI) and Functional Skills Assessment (FSA)] were noted. However, concerns were noted with regard to initial attempts to develop the FSA Quality Measure Grading Tool, as well as the lack of inter-rater reliability across all quality assessments. Overall, concerns regarding the adequacy of completed PSIs and FSAs remained.

<u>Most Integrated Setting</u>

- Most assessments prepared for annual ISP meetings now included the assessor's recommendation regarding transition to the community, but some did not. 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.
- Systemic issues appeared to prevent referrals, and clear action was not being taken to resolve them. For example, concerns were noted with regard to what was described as a DADS Guardianship Specialist policy that required individuals to have "no incidents for six months before [the DADS Guardianship Specialist] will consider community placement." Although the team appropriately questioned the policy, there was no indication that the team raised this significantly concerning "policy" to a higher level for review. Other systemic issues that negatively impacted referrals and had not been addressed were gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs.
- In the last report, the Monitoring Team raised issues regarding teams potentially delaying referrals to allow family members opposed to transition to obtain guardianship. During this review, review of individual records and other documentation showed evidence of this practice. These practices were inconsistent with the Settlement Agreement requirement that: "the State shall take action to encourage and assist individuals to move to the most integrated settings…" In none of these cases was evidence found that teams had developed detailed

and individualized action plans to work with families to identify community living options that could address their specific needs.

- Although teams were identifying obstacles to referral, they sometimes did not include all of the concerns the team had identified in their discussion. Action plans were not being developed for all obstacles. In addition, action plans that were being developed were insufficient 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.
- Although most individuals had plans in their ISPs related to educational opportunities on community options, 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 needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Expansion of efforts to share success stories was needed, particularly for individuals and guardians who were reluctant.
- On a positive note, some assessments developed in preparation for Community Living Discharge Plan (CLDP) meetings had begun to include more detail regarding the protections, treatments, and supports that individuals needed, and/or the specific clinical supports required. Although much more work was needed, it was positive that some disciplines were beginning to include more detail. Of significant concern was the fact that these more detailed recommendations were not being translated into necessary pre- and post-move required supports. Many pre- and post-move required supports continued to be missing from CLDPs, including some extremely important supports necessary to protect the wellbeing of the individuals transitioning to the community.
- At the time of the Monitoring Team's last review, three individuals that had transitioned to the community since the Settlement Agreement was signed recently had returned to the Facility. Since the last review, another individual had returned to the Facility. As noted in previous reports, the Facility was not conducting root cause analysis reviews of even these most critical incidents to determine specifically whether or not changes should be made to the CLDP development or implementation process.
- The Facility had been conducting pre-move monitoring, and this was resulting in confirmation that pre-move supports were in place prior to the individual's transition to the community. Although based on observation, the Post-Move Monitor appeared to conduct thorough post-move monitoring, review of documentation did not consistently show that findings were well supported. It is important that clear evidence be provided to support the findings and to increase the likelihood that community providers will respond to them.

<u>Consent</u>

- As previously reported, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. Staff reported that State Office had sought comments on a draft policy, and many comments were submitted. The lack of a process to assess an individual's functional capacity to render a

decision regarding health or welfare continued to be a significant challenge to moving forward with this Section of the Settlement Agreement.

- Since the last review, to assist in this process, the Human Rights Officer (HRO)/Guardianship Coordinator had met with teams to discuss the use of some existing assessments, such as the psychological, psychiatric, and speech/communication assessments. As noted in the last report, 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.
- The updated prioritized list, dated 1/8/14, included names of 64 individuals served by LBSSLC. At the time of the review, Lubbock supported 202 individuals, of whom approximately 32% were estimated to need guardians, and 68% were identified as having 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, 20 individuals were in the Priority II category, and nine were in the Priority III category.
- In addition to reviewing the prioritized list, the Guardianship Committee provided ideas related to recruiting potential guardians and advocates, as well as funding guardianship costs. For example, the Guardianship Committee was working on a brochure to use in recruitment efforts, and discussed ideas for venues at which such a brochure could be used.
- Since the Monitoring Team's last review, the Facility's efforts had resulted in guardians being appointed for five individuals, with another eight individuals in some phase of the process. Again, 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. The Guardianship Committee had begun to develop some ideas for recruiting advocates and/or guardians for individuals who needed them.

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

- According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. 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. Since the last review, the Facility had taken steps to formalize the process for requesting corrective actions related to specific record reviews, and confirming that necessary steps had been taken. This process was in the initial phases of implementation. Next steps involved identifying issues that could be addressed either as a group (e.g., as opposed to retraining one staff member, training a group of staff on the same issue), or more systemically across the Facility.
- 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 accuracy and completeness of the records,

and the maintenance of complete data, continued to have the potential to impact negatively on teams' decision-making ability.

- LBSSLC had a working system for policy and procedure development and the completion of related training. Specifically, over the last few review periods, the Facility had implemented a process to review and adopt State Office policies, and develop corresponding Facility procedures to operationalize the State Office policies as well as other procedures necessary for consistent implementation of the requirements of the Settlement Agreement. Naturally, over time, additional policies will be added, and/or revisions will be needed to current policies. The Operating Procedures Manual (OPM) Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. This group also made decisions about training on policies and procedures. With the involvement of Competency, Training, and Development (CTD), the Facility had a working system to track staff's completion of the related training. The Facility was found to be in substantial compliance with Section V.2. It is important to note that the quality or completeness of the policies, as well as the full implementation of the policies/procedures are not addressed with regard to Section V.2, but rather in other sections of this report.

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:
▪ Review of Following Documents:
o Facility's list of processes to monitor the use of restraint (TX-LB-1401-II.3), undated;
o Do Not Restrain List, revised 7/17/13;
o List of Restraint Monitors, undated;
o List of all restraints, from 5/15/13 through 11/15/13;
o List of Individuals Restrained Off Grounds from 5/15/13 through 11/15/13;
o Presentation Book for Section C;
o Curricula used to train staff on use of restraint other than Prevention and Management of Aggressive Behavior (PMAB);
o Restraint Monitor Training, by Jim Forbes, Director of Behavioral Services, undated;
o Percent of All Employees Completing Minimum Training Requirements abuse, neglect, and exploitation (A/N/E); cardiopulmonary resuscitation (CPR); PMAB, Restraint: Prevention and Use for Rules at SSLCs; and Unusual Incidents: Years 2013/2014;
o Completed Monitoring Tools for Section C;
o Self-Assessment for Section C, dated 12/20/13;
o Action Plans: Section C, dated 12/17/13;
o Minutes of the Quality Assurance/Quality Improvement (QA/QI) Committee, for June, and July 2013;
o Minutes of the Executive Safety Committee meetings for August, September, October, and November 2013;
o Behavioral Services Monitoring of Use of Restraint: May to October 2013;
o Crisis Intervention Restraint Plans, from 5/15/13 through 11/15/13;
o For the last year, list of injuries by individual, living area, and by type;
o Injuries to Staff During Use of Restraint, from 11/16/12 through 11/15/13;
o Sample #C.1: For the restraints listed in the following table, 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. Sample numbers with asterisks indicate that additional information about the first episode of restraint in a series was requested on site and supplied by the Facility.
<table>
<tr><th>Sample #</th><th>Name</th><th>Date and time</th></tr>
<tr><td>C1.1 *</td><td>Individual #288</td><td>5/30/13 at 12:02 p.m.</td></tr>
<tr><td>C1.2 *</td><td>Individual #288</td><td>6/22/13 at 9:18 a.m.</td></tr>
<tr><td>C1.3 *</td><td>Individual #288</td><td>6/25/13 at 8:59 p.m.</td></tr>
<tr><td>C1.4 *</td><td>Individual #288</td><td>6/27/13 at 10:56 a.m.</td></tr>
</table>
</td></tr>
</table>

C1.5 *	Individual #288	7/25/13 at 3:18 p.m.
C1.6 *	Individual #288	10/1/13 at 11:04 a.m.
C1.7 *	Individual #288	10/3/13 at 3:10 p.m.
C1.8 *	Individual #288	11/8/13 at 12:34 p.m.
C1.9	Individual #288	11/8/13at 12:51 p.m.
C1.10	Individual #27	6/22/13 at 4:59 p.m.
C1.11	Individual #27	7/8/13 at 6:30 p.m.
C1.12	Individual #27	10/29/13 at 7:05 p.m.
C1.13	Individual #320	6/14/13 at 11:59 p.m.
C1.14 *	Individual #320	6/20/13 at 8:51 a.m.
C1.15 *	Individual #320	10/30/13 at 3:39 p.m.
C1.16 *	Individual #4	10/3/13 at 7:15 a.m.
C1.17 *	Individual #4	10/5/13 at 1:08 p.m.
C1.18	Individual #240	9/1/13 at 5:55 p.m.
C1.19	Individual #165	7/31/13 at 1:30 p.m.
C1.20	Individual #165	8/2/13 at 7:53 a.m.
C1.21	Individual #131	7/24/13 at 1:29 p.m.
C1.22	Individual #124	8/22/13 at 4:15 p.m.
C1.23	Individual #121.	10/4/13 at 10:08 a.m.
C1.24	Individual #220	8/29/13 at 5:26 p.m.
C1.25 *	Individual #143	9/26/13 at 1:09 p.m.
C1.26 *	Individual #22.	8/3/13 at 3:48 p.m.
C1.27 *	Individual #213	5/15/13 at 7:35 a.m.
C1.28	Individual #46	7/19/13 at 2:23 p.m.
C1.29 *	Individual #38	8/23/13 at 10:25 a.m.
C1.30	Individual #60	6/4/13 at 6:46 p.m.

- A subsample of three records from #C.1 was drawn for use in regard to Section C.4. Records included the annual Medical Summary Active Problems list, the form used by the Facility to document restraint considerations/restrictions, ISPs, and ISPAs related to restraint:

Sample #	Name	Date and time
C1.1	Individual #288	5/30/13 at 12:02 p.m.
C1.20	Individual #165	8/2/13 at 7:53 a.m.
C1.30	Individual #60	6/4/13 at 6:46 p.m.

- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes (IPNs), and Client Injury Reports (CIRs) for the following individuals:
  - Individual #288 on 6/25/13 at 8:59 p.m., 6/27/13 at 10:56 a.m., 7/25/13 at 3:18

p.m., 10/1/13 at 11:04 a.m., 10/3/13 at 3:10 p.m., and 11/8/13 at 12:34 p.m.;
- Individual #27 on 6/22/13 at 4:59 p.m., 7/8/13 at 6:30 p.m., and 10/29/13 at 7:05p.m.;
- Individual #320 on 6/14/13 at 11:59 p.m., and 10/30/13 at 3:39 p.m.;
- Individual #4 on 10/3/13 at 7:15 a.m.;
- Individual #240 on 9/1/13 at 5:55 p.m.;
- Individual #165 on 8/2/13 at 7:53 a.m.;
- Individual #131 on 7/24/13 at 1:29 p.m.;
- Individual #124 on 8/22/13 at 4:15 p.m.;
- Individual #121 on 10/4/13 at 10:08 a.m.;
- Individual #220 on 8/29/13 at 5:26 p.m.;
- Individual #143 on 9/26/13 at 1:09 p.m.;
- Individual #22 on 8/3/13 at 3:48 p.m.;
- Individual #213 on 5/15/13 at 7:35 a.m.;
- Individual #46 on 7/19/13 at 2:23 p.m.;
- Individual #38 on 8/23/13 at 10:25 a.m.; and
- Individual #60 on 6/4/13 at 6:46 p.m.

- **Sample #C.2**: Not used since Section 3.C was not monitored during this site review.
- **Sample #C.3**: Medical Restraints: From the list provided in response to document request II.7, a sample of ten records was drawn as indicated 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, and the doctor's order for the restraint, including the monitoring schedule to be used and the medical restraint plan.

Sample #	Name	Date
C3.1	Individual #6	5/15/13 at 6:00 a.m.
C3.2	Individual #103	8/22/13 at 5:30 a.m.
C3.3	Individual #175	6/25/13 at 7:00 a.m.
C3.4	Individual #170	7/11/13 at 9:00 a.m.
C3.5	Individual #119	5/16/13 at 6:30 a.m.
C3.6	Individual #58	10/11/13 at 5:30 a.m.
C3.7	Individual #299	5/20/13 at 4:30 p.m.
C3.8	Individual #79	10/22/13 at 11:30 a.m.
C3.9	Individual #47	10/31/13 at 8:30 a.m.
C3.10	Individual #8	8/29/13 at 9:20 a.m.

- **Sample #C.4** Chemical Restraint Sample: From the list provided in response to document request II.7a, the total chemical restraints for crisis intervention was 25. The sample size was four, or 16%, and included the restraint checklist, the face to-face/debriefing form, any reviews of the use of this restraint, evidence of contact between the psychologist and

physician prior to the use of the restraint, and any changes to the ISP or Safety Plan as a result of the restraint. The following table identifies the sample:

Sample #	Name	Date and Time
C1.1	Individual #288	5/30/13 at 12:02 p.m.
C1.14	Individual #320	6/20/13 at 8:51 a.m.
C1.17	Individual #4	10/5/13 at 1:08 p.m.
C1.19	Individual #165	7/31/13 at 1:30 p.m.

- **Sample #C.5:** For restraint used off-grounds, the following documentation organized by individual and episode: **t**he Restraint Checklist, **f**ace-to-face/debriefing form, the safety plan, any reviews of the use of this restraint, nursing documentation, and any addenda or changes to the individual's ISP or safety plan that resulted. The following sample was reviewed:

Name	Off-grounds Restraint
Individual #38	9/24/13 at 12:00 p.m.
Individual #7	10/4/13 at 10:08 a.m.
Individual #27	10/18/13 at 6:21 p.m.
Individual #240	10/18/13 at 6:22 p.m.

- For Section C.4, Positive Behavior Support Plans (PBSPs), as available, for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274;
- **For Sample #C.6**, three individuals who were restrained more than three times in a 30-day period, with a total of 14 restraints, were selected from the list of individuals restrained as crisis intervention between May 15 2013 and November 15, 2013. Restraint records were requested, including Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Reports, Crisis Intervention Plans (CIP), Individual Support Plans (ISP), ISP Addendums, Positive Behavior Support Plans, and Monthly PBSP Progress Notes (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 #7	9/22/13	7:32 PM
	9/22/13	7:43 PM
	10/4/13	10:00 PM
	10/20/13	6:03 PM
Individual #165	8/1/13	7:51 AM
	8/1/13	8:10 AM

	8/1/13	9:14 AM
	8/1/13	9:41 AM
	8/1/13	9:50 AM
	8/1/13	8:12 AM (chemical)
Individual #320	10/30/13	2:53 PM
	10/30/13	3:36 PM
	10/30/13	3:39 PM
	10/30/13	4:40 PM

- List of individuals restrained as crisis intervention ("All Restraints in Descending Order – 05/15/13 through 11/15/13");
- For Section C.7, summary listing of individuals restrained more than three times in a 30-day period (including home, date of restraint, CIP in place, and date of ISPA]; and
- For Section C.7, Individual Support Plan Addendum, for individuals restrained more than three times in a 30-day period, as available, for: Individual #288, Individual #27, Individual #320, Individual #4, Individual #240, Individual #165, Individual #131, Individual #121, Individual #7, Individual #213, and Individual #46;
- **Sample #C.7: Protective Mechanical Restraints to Prevent Self-Injurious Behavior (PMR-SIB):** This sample was chosen from the list of Protective Mechanical Restraints, dated 5/16/13 to 11/15/13, and submitted in response to Document Request II.7. Two individuals were listed with a total of 172 restraints. Documents requested included: 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 a list of Facility approved restraints with policy reference included.

Sample #	Name	Date
C7.1	Individual #242	7/22/13 at 6:00 a.m.
C7.2	Individual #242	10/28/13 at 4:20 p.m.
C7.3	Individual #317	6/12/13 at 1:30 p.m.

- **Interviews with**:
  - Libby Allen, Facility Director;
  - Robin Seale, Assistant Director of Programs (ADOP);
  - Rodney McWilliams, Incident Management Coordinator (IMC);
  - Jim Forbes, M.Ed., BCBA, Director of Behavioral Services;
  - Dawn Ripley, Director of Quality Assurance;
  - Brandi Villarreal, RN, BSN, Chief Nurse Executive (CNE);
  - Lilly Burton, RN, Program Compliance Nurse;
  - Ruth Clark, RN, Quality Assurance Nurse; and
  - Informal interviews/conversations with staff and individuals.

	▪ **Observations of**: o The Quality Assurance/Quality Improvement Council, on 1/7/14; o Presentation on the Corrective Action Plan for Infection Control, on 1/7/14; o Unit I and II Morning Meeting, on 1/8/14; o Incident Management Meeting, on 1/8/14; o Executive Safety Committee, on 1/8/14; o Visits to Residences #520, #517, #515, #528, #527, and #526; and o Visits to the large and small workshops.
	Facility Self-Assessment: The Lubbock State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance six of the 14 provisions in Section C of the Settlement Agreement. The Monitoring Team found the Facility to be in substantial compliance with four of the 14 provisions. In its Self-Assessment, dated 12/20/13, 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. This list was different from the one the Program Compliance Monitor (PCM) used. While this arrangement did not allow for inter-rater reliability to be measured, it did provide two strong reviews of the elements of compliance. ▪ 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 Behavioral Services Department monitored documentation for all crisis intervention restraints for compliance with the Settlement Agreement, and used data from those reviews in the self-assessment. ▪ 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. ▪ The monitoring/audit tools the PCMs used 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 appeared that the staff persons responsible for conducting the audits were competent in the use of the tools and that they were clinically/programmatically competent in the relevant area(s). For Section C, no information was provided regarding inter-rater reliability. ▪ The Facility used some relevant data sources and was beginning to use 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, and Facility staff had begun to collect data. However, the results were not referenced in the Self-Assessment. ▪ The Facility consistently presented some of the data in a meaningful/useful way: o Generally presented findings consistently based on specific, measurable indicators rather than on overall composite scores. o Presented data in charts and tables across six months to allow for easy comparisons. o Included comments and examples to explain differences or irregularities in data. ▪ When the Facility's data identified some areas in need of improvement, it provided 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 four out of 14 provisions of Section C, as opposed to the three provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ Trend reports not only tracked restraints over time, but that tracking information was compared with other data in the Executive Safety Committee to inform decision-making. ▪ The Executive Safety Committee had developed into a valuable resource for reviewing, comparing, and making decisions based on a variety of data streams. Because it included the highest level of management, the Committee was well positioned to act based on the data analyses that it reviewed, and there was evidence that actions were being taken to create a safer environment for the individuals who resided at the Facility. ▪ There were improvements in pharmacy reports for post-chemical restraint in recent months. ▪ The timeliness of nurses responding to restraints had seen improvement since August. ▪ Restraint use was being reviewed at Unit meetings, incident management meetings, and by interdisciplinary teams (IDTs) following most restraints, and new procedures were put in place to assure accurate documentation of the IMRT's reviews. ▪ The quality monitoring the Behavior Services Department and the Program Compliance Monitor served to identify and direct corrections to processes that helped bring this section closer to compliance with the Settlement Agreement. 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: ▪ Achieve closure on the issue of orders for medical/dental restraints. The physicians' orders need to include the schedule and type of monitoring, and monitoring according to the prescribed schedule needs to occur and be evident in the restraint documentation. ▪ After the onsite review, the Monitoring Team raised issues to the State Office surrounding timely medical treatment for individuals who might need the use of pre-treatment sedation to cooperate with dental or medical procedures. In response, State Office indicated that it subsequently had worked with the Facility to ensure that the answers to the legal questions that had been raised were communicated to medical staff, and individuals for whom delays in care had occurred received the care they needed. It will be essential going forward for follow-up to occur to ensure this issue has been resolved, and does not continue to impact individuals. ▪ In addition, issues needed resolution around who might need desensitization efforts or other strategies to help them accept treatment without medications or restraints. It will be essential for careful review to occur of individuals receiving various forms of sedation (e.g., pre-treatment sedation, intravenous sedation, and general anesthesia) to determine who might benefit from plans to potentially reduce the need for such practices, and for such plans to be developed and implemented.

<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>Data the Facility provided showed:
<table>
<tr><th>Type of Restraint</th><th>12/1/12 to 5/31/13</th><th>6/1/13 to 11/30/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>187</td><td>227</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>39</td><td>23</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>226</td><td>250</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>22</td><td>26</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>8</td><td>7</td></tr>
<tr><td>Medical/dental restraints</td><td>127</td><td>24*</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>16</td><td>9</td></tr>
<tr><td>Protective Mechanical Restraints for SIB</td><td>101</td><td>178</td></tr>
<tr><td>Total individuals restrained for PMR/SIB</td><td>1</td><td>2</td></tr>
</table>
* The reason for the sharp decrease in use of medical restraints was not clear. It might be related to issues with care and/or definitions the Facility was using.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Prone Restraint 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 Reviewed Section above.) c. Based on a review of the restraint records for individuals in Sample #C.1, none (0%) showed use of prone restraint. d. Based on questions with 10 direct support professionals, all were aware of the prohibition on prone restraint. Other Restraint Requirements e. Based on document review, the Facility and State policies indicated that restraints could 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. 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 30 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. ▪ i. Facility policies did identify a list of approved restraints as those listed on the Restraint Checklist.	

#	Provision	Assessment of Status	Compliance
		▪ j. Based on the review of 26 restraints, involving 26 individuals, 26 (100%) were approved restraints. The remaining restraints in sample #C1 were chemical restraints. 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 Samples #C1.12, where it was not clear what activities were supposed to be going on and so it could not be determined if appropriate treatment was available to the individual, and #C1.24, where the individual was described as waiting for dinner and seeking attention. From experience, the period before a meal can be one where individuals are gathered to wait with little to occupy them or distract them from the wait, and from the available documentation, it was not clear whether this might have been the case. l. Of the three restraints reviewed that the Facility considered PMR-SIB (i.e., Sample C.7), three (100%) followed State Office policy regarding the use, management, and review of PMR-SIB. While the ISP and ISPAs documented reviews and discussion of the use of abdominal binders, the teams need to include the resulting actions within the ISP Action Plans to assure continued compliance with this provision. Based on the Monitoring Team's review, the Facility was in substantial compliance with this provision. The Facility's finding in the Self-Assessment also concluded that the Facility was in substantial compliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
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 that restraint was used as a crisis intervention. b. In an attempt to examine whether or not restraints were used for anything other than crisis intervention, a sample of 13 individuals who had ISPs within the last six months and who also had PBSPs was selected. Based on the PBSP Master List, dated 12/12/13, this sample of 13 individuals reflected 10% of total number of individuals with PBSPs currently in place (N=133). Of the 13 PBSPs reviewed, in 13 (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. 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 the Facility maintained. e. In three of three restraint records reviewed (100%) (i.e., the subsample of Sample #C1, as listed in the documents reviewed section), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form the Facility used to document restraint considerations/restrictions. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in the Monitoring Team's previous reports, the numbers of individuals the Facility identified as requiring and/or having dental and/or medical desensitization programs has varied considerably. For example, the Monitoring Team's past reports have noted the total number of individuals with dental desensitization plans ranged from a high of 113 to a low of 37. At the time of the Monitoring Team's last visit, it was clear that the Facility's Desensitization Committee was intent on revising the guidelines, including how important terms were defined (e.g., what is a "routine" dental procedure) and related 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. The dramatic changes in the number of SAPs appeared related to this ongoing process. Currently, it appeared that these revisions had continued. That is, additional changes were recently voiced with regard to the direction that IDTs were given to determine whether or not individuals met the criteria for desensitization programming. At this time, it appeared that the decision to develop desensitization programming for an individual was based more on the type of dental or medical procedure needed and based less on the skills or needs of the individual. Unfortunately, at the time of the recent visit, it appeared that the committee responsible for examining this issue (i.e., the Desensitization Committee) had been discontinued. This issue is indeed complex and continues to require thoughtful consideration. In response, the Monitoring Team has discussed this issue with regard to Section J.4 and Q.2 of the Settlement Agreement. In the end, it still appears that the Facility's efforts at determining an effective process for identifying individuals who might benefit or need desensitization programming was still unresolved. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work (i.e., Sample #C3): ▪ g. Seven (70%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). The three that did not were: o Samples #C3.1and #C3.7, where no HRC approval forms or consent forms were found; and o Sample #C3.8, where there were no HRC or approval forms, but an explanation indicated those forms were not needed since the medical restraint was an elevation of a regular dose of medication. Given that elevation of a dose of medication had the express purpose of rendering the individual amenable to other treatment, it took on the characteristics of a restraint and should have had evidence of consent and the same HRC review as any other medical restraint. Sampled medical and dental desensitization plans (i.e., Individual #276, Individual #258,	

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		Individual #217, Individual #109, Individual #232, and Individual #274) and corresponding data (i.e., Individual #103, Individual #6, Individual #79, Individual #175, Individual #8, Individual #47, Individual #299, and Individual #119) were determined to be inadequate. This finding was consistent with the findings for other sampled SAPs currently reviewed. Overall, it continued to be unlikely that the majority of SAPs, including dental and medical desensitization programs, were currently promoting growth, development, and independence across most individuals served at LBSSLC. Based on this review: • h. None of the six (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • i. One of eight (13%) (i.e., Individual #175) 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	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, 25 staff at the Facility who performed the duties of a restraint monitor (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. This included the staff who were listed as restraint monitors for the 30 restraints in Sample #C1. Based on a review of 30 restraint records (Sample #C1), a face-to-face assessment was conducted. ▪ d. In 30 out of 30 incidents of restraint (100%) by an adequately trained staff member. ▪ 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. ▪ f. In 27 instances (90%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: Sample #C1.12, where the Restraint Checklist did not include a description of behavior before the restraint-causing behavior; Sample #C1.13, where the restraint monitor did not identify that the restraint	Noncompliance

#	Provision	Assessment of Status	Compliance
	order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	checklist had a release code "I" meaning the release procedure was started, but did not have a code for the actual time when the release was accomplished; and Sample #C1.24, where the restraint monitor did not explain the lack of activity noted on the Restraint Checklist. ▪ g. In 29 instances (97%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: Sample #C1.19, where it was noted that staff reactions to the restraint were not addressed, but provided no explanatory comments. There were no reported restraints for which physicians had ordered alternative monitoring schedules. Had there been, the following metrics would have been applied: ▪ h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 24 restraint records for 16 individuals for restraints that occurred at the Facility (i.e., Individual #288, Individual #27, Individual #320, Individual #4, Individual #240, Individual #165, Individual #131, Individual #124, Individual #121, Individual #220, Individual #143, Individual #22, Individual #213, Individual #46, Individual #38, and Individual #60), there was documentation that a licensed health care professional: ▪ j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in 23 (96%) of the instances of restraint. The record that did not contain documentation of this included: Individual #220 on 8/29/13 at 5:26 p.m. ▪ k. Monitored and documented vital signs in 13 (54%) episodes. Records that did not contain appropriate documentation of this included: Individual #288 on 10/1/13 at 11:04 a.m., and 11/8/13 at 12:34 p.m.; Individual #27 on 7/8/13 at 6:30 p.m.; Individual #320 on 6/14/13 at 11:59 p.m.; Individual #4 on 10/3/13 at 7:15 a.m.; Individual #240 on 9/1/13 at 5:55 p.m.; Individual #165 on 8/2/13 at 7:53 a.m.; Individual #124 on 8/22/13 at 4:15 p.m.; Individual #220 on 8/29/13 at 5:26 p.m.; Individual #213 on 5/15/13 at 7:35 a.m.; and Individual #46 on 7/19/13 at 2:23 p.m. Problematic issues that resulted in noncompliance included variations in the vital signs not retaken, and 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 22 (92%) episodes. Records that did not contain appropriate documentation of this included: Individual #288 on 7/25/13 at 3:18 p.m.; and Individual #220 on 8/29/13 at 5:26 p.m. Problematic issues that resulted in noncompliance included either the mental status was not recorded, or was generic such as "responsive" without a specific description of	

#	Provision	Assessment of Status	Compliance
		the behavior included to support the generic documentation. The following were not applicable: Based on documentation provided by the Facility, ___ restraints had occurred off the grounds of the Facility in the last six months. A sample of __ 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 __ out of ___ (__%). Records that did not contain documentation of this included… ▪ n. Monitored and documented vital signs in ___ (___%). Records that did not contain documentation of this included… ▪ o. Monitored and documented mental status in ___ (___%). Records that did not contain documentation of this included… Sample #C3 of ten medical/dental restraints was selected from the list of 46 individuals who had medical restraint between 5/15/13 and 11/15/13, representing 22% of the individuals for whom medical restraint was used. (Sample #C3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In one out of ten (10%), the physician specified the schedule of monitoring required or specified Facility policy regarding this was followed. While, there was a physician's order for the restraint that specified the dosage or the mechanical restraint to be used, orders did not indicate what sort of monitoring should be done or who should do it. One that did was Sample #C3.3, where the physician noted the individual should be monitored on a one-to-one basis for at least four hours. ▪ q. In two out of ten (20%), the physician specified the type of monitoring required if it was different than the Facility policy. Those were samples #C3.1 and #C3.6. ▪ r. In seven out of ten of the medical restraints (70%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. Those where monitoring was not completed as specified or as per policy or the Settlement Agreement were: o Sample #C3.1 where an abdominal binder was used, monitored every two hours for circulation checks from 6 a.m. to 2 p.m., then neither removed nor monitored for several hours without explanation. o Samples #C3.8 and #C3.10, where the monitoring for chemical restraints did not appear to follow the time schedule printed on the restraint checklist. Based on this review, the Facility was noncompliant with this provision of the Settlement Agreement. To move forward, when physicians order medical or dental restraint, the	

#	Provision	Assessment of Status	Compliance
		order needs to include the schedule and type of monitoring to be accomplished, or specifically reference the applicable Facility policy, and then the monitoring should be completed as ordered.	
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 30 (100%), continuous one-to-one supervision was provided; ▪ 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 happened before, including what was happening prior to the change in the behavior that led to the use of restraint The two that did not have this information were: o Sample #C1.12, where it was not clear what preceded the attempt to hit a peer and necessitated staff intervention. o Sample #C1.28, where the restraint checklist, the face-to-face, and the debriefing sheet did not clarify what had preceded the individual's attack on staff and subsequent restraint. However, the ISPA a month later did report that the individual had attempted to follow a staff person to the restroom and was redirected from that attempt, resulting in the attack on staff. Such information was important so that the manner staff used to redirect could be explored to determine whether there could have been improvements. ▪ e. In 30 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Section C.8. ▪ 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; ▪ In the 26 instances of physical restraint, observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In 26 (100%), the observations documented every 15 minutes and at release; o j. In the one of those restraints that lasted more than 15 minutes (100%), the specific behaviors of the individual that required continuing restraint; and o k. There were no restraints in the sample that lasted more than 30 minutes. If there had been, the Monitoring Team would have assessed the care provided by staff during restraint lasting more than 30 minutes, 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ l. In 26 (100%), the level of supervision provided during the restraint episode; ▪ m. In 26 (100%), the date and time the individual was released from restraint. n. Based on a review of 24 restraint records for 16 individuals for restraints that occurred at the Facility (i.e., Individual #288, Individual #27, Individual #320, Individual #4, Individual #240, Individual #165, Individual #131, Individual #124, Individual #121, Individual #220, Individual #143, Individual #22, Individual #213, Individual #46, Individual #38, and Individual #60): ▪ In 24 (100%), 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. o. In a sample of 30 records (Sample #C.1), restraint debriefing forms had been completed for 27 (90%). The documentation that was present, but incomplete included: ▪ Sample #C1.12, where the debriefing form did not provide a complete description of what was happening before the behavior that occasioned the restraint (as discussed above with regard to C.1.k and C.5.f); ▪ Sample #C1.24, where the debriefing form did not explain whether the attention seeking behavior that led to the restraint was the result of lack of program/activities (as discussed above with regard to C.5.f); and ▪ Sample #C1.15, where the debriefing was documented as completed at 3:25 p.m., but the restraint did not end until 3:42 p.m. p. A sample of 10 individuals subject to medical restraint was reviewed (Sample #C.3), and in seven (70%), there was evidence that the monitoring had been completed as required by the physician's order, the protocol as printed on the restraint checklist, or in compliance with the Settlement Agreement (as discussed above with regard to C.5.r). Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. This sample of four individuals who were the subject of a chemical restraint was reviewed: q. In four (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 remained in noncompliance with this provision due to the need for medical restraints to be monitored consistently.	

#	Provision	Assessment of Status	Compliance
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation identifying individuals restrained between May 15, 2013 and November 15, 2013, a total of 11 individuals were placed in physical restraint more than three times in any rolling 30-day period. Of these 11 individuals, a random sample (Sample #C.6) of three of these individuals (reflecting a sample of 27%) was selected for review to determine if the requirements of the Settlement Agreement were met. For each individual selected, four (or more) consecutive physical 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). It should be noted that the current review targeted individuals with consecutive physical restraints and not individuals with protective mechanical restraints (e.g., abdominal binder). Documentation requested for review included Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, Crisis Intervention Plans, Positive Behavior Support Plans, Individual Support Plans, ISP Addendums, and Monthly PBSP Progress notes (for the current month of the identified restraints as well as the month prior and the month following). It should be noted that the PBSP and Crisis Intervention Plan in place at the time of the restraints were requested and subsequently reviewed, as available. The results of this review, based on provided documentation, are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. a. For two individuals (67%), 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 where this did occur: o An ISPA dated 8/2/13 indicated that the IDT for Individual #165 met and discussed the five physical and one chemical restraint that occurred on 8/1/13, The ISPA template designed to facilitate adequate team review (following more than three restraints in any rolling 30-day period) appeared to be completed (specific details are provided below). o The IDT for Individual #320 did meet following the more than three restraints in a rolling 30-day period as specifically identified above. That is, the IDT did meet (on 10/31/13) to discuss the four restraints that occurred on 10/30/13 (as noted in the ISPA dated 10/31/13). However, although the IDT did meet in a timely fashion, the team did not utilize the required ISPA	Noncompliance

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		template designed to facilitate adequate IDT review (i.e., following more than three restraints in any rolling 30-day period). Indeed, the documented IDT discussion was very brief and appeared devoid of any in-depth and comprehensive review. According to a previous ISPA, dated 7/19/13, the IDT met to discuss four or more restraints in a 30-day period that occurred between 6/11/13 and 7/7/13. Notably, at that time, the required ISPA template was completed reflecting a much more comprehensive IDT review. It was unknown to the Monitoring Team why a similar ISPA review had not been completed for the restraints documented on 10/30/13. Given that these recent restraints occurred in excess of 90 days from the last restraint (on 7/7/13) reviewed by the IDT, according to current policy, a subsequent comprehensive IDT review and ISPA should have been 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 #7 did meet following the more than three restraints in a rolling 30-day period as specifically identified above. However, the provided ISPAs did not evidence an adequate or timely review of all of the restraints by the IDT. As detailed above, four physical restraints (in a rolling 30-day period) were reported for Individual #7. More specifically, the first and second physical restraint occurred on 9/22/13, the third physical restraint on 10/4/13, and the fourth on 10/20/13. According to ISPAs, the IDT met on 9/23/13 and reviewed the first and second restraints and met on 10/21/13 to discuss the fourth restraint. These meetings met the criteria of meeting within one business day following the use of restraint with someone who does not have a CIP. However, the IDT did not meet to discuss the third restraint (that occurred on 10/4/13) until 10/30/13 or 10/31/13. The exact date of meeting was unclear to the Monitoring Team as the date listed on the face and signature pages of the ISPA indicated "10/31/13," and the date identified within the text was "10/30/13." Nonetheless, as noted in the ISPA (dated 10/31/13), the IDT review was delayed because the restraint checklists were unavailable. And, this ISPA detailed discussion of the IDT that focused solely on the restraint that occurred on 10/4/13. As a result, the Monitoring Team determined that this final review was problematic based on inadequate timeliness and the lack of a comprehensive review (i.e., examining the restraints more as a whole than individual occurrences). More specifically, the timing of reviews led the Monitoring Team to question the adequacy of the IDT's ongoing oversight. At the very least, the last IDT review (ISPA dated 10/31/13) should have included a comprehensive review of all four restraints. More importantly, the required ISPA format (i.e., the format the IDT used when reviewing more than three restraints in any	

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		30-day rolling period) was not utilized for any of the completed ISPAs. Lastly, although three of the four restraints were reviewed within one business day, the third restraint was not reviewed by the IDT for at least 18 business days. In the end, these reviews did not appear consistent with the Facility's policy or with the intent of this section of the Settlement Agreement. 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 only two of the sampled individuals (i.e., Individual #165 and Individual #320) and the findings are discussed below with regard to Sections C.7.b through C.7.g of the Settlement Agreement. It should be noted that, although the use of the ISPA template designed to facilitate adequate IDT review following more than three restraints in any rolling 30-day period was not adequately reflected in the current sample, documentation the Facility provided appeared to suggest that the template was being utilized more than the current sample would suggest. More specifically, documentation revealed that the ISPA template was frequently completed for the majority of individuals who met criteria of more than three restraints in any rolling 30-day period. For example, the Monitoring Team identified 11 individuals who met criteria of more than three restraints in any rolling 30-day period day period (between 5/15/13 and 11/15/13). Curiously, this list of individuals was inconsistent with the list the Facility generated. That is, the Facility did not include three individuals that, based on the Monitoring Team's review, appeared to meet criteria. The exceptions included Individual #121, Individual #7, and Individual #213. It was noted that one of the individuals the Facility overlooked was one of the individuals sampled above (i.e., Individual #7). Nonetheless, documentation indicated that, for the eight individuals identified, the required ISP template was used in 14 (82%) of the ISPAs provided. b. Of the two individuals reviewed, one (50%) of individuals' teams (as reflected in ISPAs) adequately 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. The following are examples of where teams failed to do this adequately: o The ISPA for Individual #320, dated 10/31/13, did not evidence discussion of the individual's adaptive skills and potential biological/medical factors. However, the IDT did discuss one potential psychosocial factor that included his preference for tobacco and perhaps a variety of choices. This reflected perhaps an	

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		underlying addiction to nicotine, although, not directly discussed by the IDT. In addition, the IDT did not appear to actively discuss the replacement behavior listed in the PBSP (i.e., asking for other options), and how this behavior may or may not have helped ameliorate the responses that led to restraint. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two (100%) of the cases. Of these, there was evidence of an action plan, discussion, or recommendations, as identified in the ISPA, for modifying them to prevent the future probability of restraint in two (100%) of the cases. 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 that 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. In addition, the Facility should ensure conspicuous consideration and/or identification of potential contributing factors (e.g., adaptive behavior and medical, psychiatric, and psychosocial variables).	
	(b) review possibly contributing environmental conditions;	a. For two (67%) of the individuals sampled, 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 exception, as described above, was Individual #7. b. Of the two individuals reviewed, one (50%) (i.e., Individual #165) of individuals' teams (as reflected in ISPAs) appeared to discuss potentially contributing environmental conditions. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in one (50%) of the cases. Of these, there was evidence of an action plan, discussion or recommendation, as identified in the ISPA, for modifying them to prevent the future probability of restraint in none (0%) of the cases. ▪ Although the ISPA for Individual #165, dated 8/2/13, evidenced a number of potentially contributing environmental conditions, these did not appear to be specifically and conspicuously addressed in the recommendations. 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 documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with IDTs to ensure adequate discussion involving potential	Noncompliance

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		environmental conditions that might have contributed to each target behavior that led to restraint.	
	(c) review or perform structural assessments of the behavior provoking restraints;	a. For two (67%) of the individuals sampled, 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 exception, as described above, was Individual #7. b. 50% of these ISPAs (i.e., Individual #165) reflected a full discussion of potential environmental antecedents to the behaviors that provoke restraint. The following is an example of where a team failed to do this adequately: ▪ The ISPA for Individual #320, dated 10/31/13, did evidence discussion of the potential environmental antecedents to the behaviors that provoked restraint. In this case, the IDT discussed the potential access to another peer's tobacco. However, additional antecedents to attempted pica were not discussed. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in two (100%) of the cases. Of these, there was evidence of an action plan for modifying them to prevent the future probability of restraint in two (100%) of the cases. However, as noted above, for Individual #320, not all potential environmental antecedents were discussed, so it was not clear the action plans fully addressed the necessary components. 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 documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with teams to ensure conspicuous evidence of IDT discussion regarding potential environmental antecedents likely precipitating identified behaviors that lead to restraint.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	a. For two (67%) of the individuals sampled, 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 exception, as described above, was Individual #7. b. 50% of ISPAs (i.e., Individual #165) reflected a discussion of the variable or variables that potentially are maintaining the behavior provoking restraints. The following are examples of where teams failed to do this adequately: ▪ The ISPA for Individual #320, dated 10/31/13, did not evidence discussion	Noncompliance

#	Provision	Assessment of Status	Compliance
		of the underlying function of aggression, elopement, or attempted pica. In addition, there was no IDT discussion regarding the current structural and functional assessment and whether or not it remained accurate and/or needed to be revised c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoked 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 none of the one (50%) of the cases. 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 documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with teams to ensure conspicuous evidence of IDT discussion and related recommendations regarding potential variable(s) that likely maintain the behaviors that lead to restraint, as well as the need for IDT discussion regarding the current structural and functional assessment and whether or not it remained accurate and/or needed to be revised.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out	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, one (50%) individual had a CIP in place at the time of the selected restraints. b. 100% of PBSPs reviewed had operationally defined target behaviors. c. 100% of PBSPs reviewed contained functional replacement behaviors (when practical and possible). d. 100% of PBSPs reviewed specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. e. One (50%) of PBSPs reviewed contained interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment (i.e., Individual #165). For Individual #320, the ISPA, dated 10/31/13, did not evidence IDT discussion that the SFA currently in place was still considered adequate. As a result, it could not be confirmed that the PBSP was based on a current functional assessment. f. One (100%) crisis intervention plan delineated the type of restraint authorized.	Noncompliance

#	Provision	Assessment of Status	Compliance
	in the individual's ISP;	g. One (100%) crisis intervention plan specified the maximum duration of restraint authorized. h. One (100%) crisis intervention plans specified the designated approved restraint situation. i. One (100%) of crisis intervention plans specified the criteria for terminating the use of the restraint. For the Facility to attain substantial compliance, PBSPs should contain interventions to weaken or reduce the behaviors that provoked the restraint, based on a current functional assessment.	
	(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. Of the two individuals reviewed, one (50%) individual (i.e., Individual #320) had presence of treatment integrity data. ▪ No collection of treatment integrity data was found in the monthly PBSP note at the time of the restraints for Individual #165. b. Of the two individuals reviewed, one (50%) of the individuals' treatment plans (i.e., Individual #320) were implemented with at least 80% treatment integrity ▪ Descriptions of "integrity issues" and lack of integrity on the monthly PBSP note for Individual #165 at the time of the restraints did not evidenced acceptable treatment integrity. 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 adequate completion of integrity checks, and ongoing documentation and monitoring (e.g., inclusion in monthly PBSP notes). When estimates are below 80%, then IDTs should take action to improve treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	a. In one (50%) of the two cases (i.e., Individual #165), there was evidence of a review of the PBSP in the ISPA for individuals having more than three restraints in a rolling 30 days. b. Of these individuals, the ISPA indicated that a revision was necessary in none (0%) of the cases. As a result, there was no need for review of evidence of a revision to the PBSP. The Facility remained out of compliance with this provision. To move in the direction of	Noncompliance

#	Provision	Assessment of Status	Compliance
		substantial compliance, the Monitoring Team recommends that the Facility ensure that IDTs actively discuss the adequacy of the current PBSP, whether or not it needs to be revised and, if so, that the PBSP is revised, reviewed, and implemented in a timely manner.	
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 five incidents of crisis intervention restraint was reviewed including: Samples #C1.7, #C1.15, #C1.17, #C1.23, and #C1.25. The sample was chosen based on restraints since 9/24/13, due to the enhancement in IMRT reviews that was introduced on that date. Documentation included the Unit Team meeting minutes, the IMRT meeting minutes, Restraint Reduction Committee minutes, ISP addenda, and the debriefing sheet for each restraint. This documentation showed that: ▪ a. In five (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 five (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 five (100%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. ▪ d. In five (100%), 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 emergency nature of the behavior that resulted in restraint. A newly instituted format for the IMRT review process, that guided the IMRT discussion by posing additional question for the IMRT to answer, was in use for three of the five restraints, and appeared to provide additional information in a straightforward manner. The three that used the new format were Samples #C1.7, #C1.15, and #C1.25. ▪ e. In five (100%), referrals were made to the team, as appropriate, because local procedure called for all restraints to be reviewed by the IDT if there was no Crisis Intervention Plan in place, or if the restraint was more than three that occurred within a 30-day period. As a result the teams reviewed all five, but the IMRT did not have to request it. ▪ f. Of the five reviewed by the IDTs, five resulted in appropriate changes being made to the individuals' ISPs and/or PBSPs.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on this review the Facility was in substantial compliance with this provision. The enhanced IMRT procedure appeared to be a good step toward assuring that reviews were documented thoroughly in the IMRT minutes.	

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 Incident Management: Managing Unusual Incidents, dated 11/20/13 (R); o LBSSLC Incident Management: Observation Note Audit Procedure, dated 4/11/13 (revised); o Alphabetical list of individuals with all incidents and injuries, from 11/16/12 through 11/15/13; o Attachment A: Executive Safety Committee, dated 1/8/14 (containing list of completed Observation Note Audits); o Observation Note Audit Results: January 2013 through June 2013, dated 12/18/13; o Meeting Minutes of the Executive Safety Committee for the 1/8/14 meeting, dated 1/9/14; o Executive Safety Committee: Addressing December 2012 - May 2013, revised 7/12/13; o Executive Safety Committee: Addressing June 2013 – November 2013, revised 1/9/14; o QA/QI Council Meetings: Addressing March 2013 - August 2013; April 2013 - September 2013, and May 2013 - October 2013; o Sample #D.1: included a sample of DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports, including the following:

Sample ID#	Name	Date Notified	Facility #	DFPS #
D1.1	Individual #239	6/18/13	13-158	42780484
D1.2	Individual #94	7/3/13	13-163	42795087
D1.3	Individual #154	7/15/13	13-169	42805969
D1.4	Individual #173	7/29/13	13-180	42818573
D1.5	Individual #239	8/7/13	13-188	42828850
D1.6	Individual #131	8/15/13	13-193	42836084
D1.7	Individual #7	8/20/13	13-197	42840991
D1.8	Individual #235	9/3/13	14-002	42855164

D1.9	Individual #309	9/12/13	14-012	42864555
D1.10	Individual #76	9/18/13	14-015	42872353
D1.11	Individual #154	10/3/13	14-022	42889557
D1.12	Individual #82	10/18/13	14-032	42905052
D1.13	Individual #154	11/2/13	14-041	42921711
D1.14	Individual #276	11/3/13	14-042	42922414
D1.15	Individual #115	11/12/13	14-050	42932354

- Sample #D.2: included a sample of Facility-only investigation reports selected from the document the Facility provided listing investigations completed over the last six months, including:

Sample #	Name	Date	Facility #
D2.1	Individual #298	5/31/13	13-151
D2.2	Individual #7	6/22/13	13-160
D2.3	Individual #274	7/9/13	13-165
D2.4	Individual #182	7/29/13	13-181
D2.5	Individual #29	8/19/13	13-196
D2.6	Individual #220	8/29/13	13-202
D2.7	Individual #196	8/31/13	13-205
D2.8	Individual #27	9/9/13	14-009
D2.9	Individual #114	9/26/13	14-018
D2.10	Individual #78	10/11/13	14-029
D2.11	Individual #204	10/30/13	14-040

D2.12	Individual #251	11/13/13	14-051

- Sample #D.3: no additional incident reports were selected.
- Sample #D.4: the sample of Individual Support Plans (ISPs) reviewed included:

Sample #	Name	Date of ISP
D4.1	Individual #7	8/12/13
D4.2	Individual #199	10/23/13
D4.3	Individual #20	10/17/13
D4.4	Individual #65	10/13/13
D4.5	Individual #109	10/14/13
D4.6	Individual #269	10/2/13
D4.7	Individual #97	9/16/13
D4.8	Individual #139	10/16/13
D4.9	Individual #21	9/17/13
D4.10	Individual #315	10/4/13
D4.11	Individual #214	10/10/13
D4.12	Individual #3	10/9/13
D4.13	Individual #240	10/3/13
D4.14	Individual #156	10/10/13
D4.15	Individual #288	8/26/13
D4.16	Individual #27	7/3/13
D4.17	Individual #320	6/13/13
D4.18	Individual #4	5/7/13
D4.19	Individual #165	11/18/13
D4.20	Individual #131	6/28/13
D4.21	Individual #121	5/1/13
D4.22	Individual #213	5/28/13

- Sample #D.5: a subsample of the investigations included in Samples #D.1 and #D.2. This included investigation reports in which programmatic recommendations were made and/or the IMRT made recommendations, including:

Sample #
D1.8
D1.10
D1.11
D2.11
D2.12

- Sample #D.6: Ten audit reports were sampled to determine whether significant injuries had been reported:

Sample #	Name	Date Audit Completed
D6.1	Individual #233	8/26/13
D6.2	Individual #53	10/31/13
D6.3	Individual #265	12/28/13
D6.4	Individual #213	12/9/13
D6.5	Individual #293	12/6/13
D6.6	Individual #309	12/28/13
D6.7	Individual #46	12/31/13
D6.8	Individual #137	11/5/13
D6.9	Individual #25	12/15/13
D6.10	Individual #198	12/28/13

- Sample #D.7: a sample of three action plan developed as a result of trend analysis:
  - Peer-to-Peer Sexual Incidents, dated 10/15/13;
  - Peer-to-Peer aggression, dated 12/2/13; and
  - Plan for slips and falls, outlined in minutes of Executive Safety Committee, dated 11/25/13.

- **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; and
  - Informal interviews/conversations with staff and individuals.
- **Observations of**:
  - The Quality Assurance/Quality Improvement Council, on 1/7/14;
  - Presentation on the Corrective Action Plan for Infection Control, on 1/7/14;
  - Unit I and II Morning Meeting, on 1/8/14;
  - Incident Management Meeting, on 1/8/14;
  - Executive Safety Committee, on 1/8/14;
  - Visits to Residences #520, #517, #515, #528, #527 and #526; and
  - Visits to the large and small workshops.

Facility Self-Assessment: The LBSSLC Self-Assessment indicated the Facility was in substantial compliance with 22 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 22 of the 22 as well.

	The Facility submitted a Self-Assessment for Section D, dated 12/20/13. 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 D, in conducting its self-assessment: ▪ The Facility used a monitoring tool. Based on a review of the Facility Self-Assessment, the monitoring templates and guidelines, a sample of completed monitoring tools, inter-rater reliability data, as well as interviews with staff: o The monitoring tool the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management." In conducting its self-assessment, the Facility selected a sample of investigations from the database of all cases from the previous two months, and applied this tool. o This monitoring tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement. o The monitoring tool included some adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed. Interviews and observation were to be conducted as appropriate. However, "appropriate" was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist of documentation review alone. As illustrated in the Monitoring Team's report, even with the limited time the Monitoring Team has at the Facility (i.e., two weeks out of the year), it is important when assessing protection from harm to conduct some staff and individual interviews and conduct observations. Staff responsible for monitoring Section D, who are located at the Facility throughout the year, should engage in these activities as well. o The Self-Assessment identified the sample sizes, including the number of records reviewed (24) in comparison with the number of investigations (114) during the period, or 21%. This sample size was adequate to consider it a representative sample. o The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: a Program Compliance Monitor from the Quality Assurance Department and the Incident Management Coordinator worked collaboratively to conduct the monitoring. o From the resume provided by the Facility for the newly hired Program Compliance Monitor, it appeared she was well qualified to conduct the monitoring. It was noted that the PCM was not available during October and November due to turnover in the position. o According to the information provided, adequate inter-rater reliability was reviewed, but had not been consistently established between the various Facility staff responsible for the completion of the tools. This remained a priority issue for the Facility, particularly with the addition of a new PCM.

	▪ The Facility used some relevant data sources and/or key indicators/outcome measures. In addition to data from the audits of investigation files, the Facility also cited some other data in its Self-Assessment. For example, it used data from the Competency and Training Department (CTD) database on A/N/E training, and data from a tracking system for alleged perpetrators. The Facility did not present data on key indicators or outcome measures in its Self-Assessment, although key indicators had been identified for the section and data had begun to be collected. ▪ The Facility consistently presented some data in a meaningful/useful way, but more work was needed. Specifically: o Many of the findings were presented as specific, measurable indicators. However, some indicators were missing. For example, for Section D.3.e the Facility reported on timely commencement of and completion of investigation reports. However, the provision also requires a report with findings and recommendations for corrective action as appropriate. o Consistently did not measure the quality as well as presence of items.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 22 out of 22 provisions of Section D, as opposed to 20 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 had made major progress in developing a working process for reviewing complex data streams and identifying trends, including issues and individuals in need of focused attention. The data presentations appeared comprehensive and useful, and the committee's efforts were demonstrating how data could drive decision-making. ▪ The injury audit procedure was in place and producing useful information. ▪ Recommendations were found in Department of Family and Protective Services reports and in Unusual Incident Reports, as well as in the review check sheets the Director completed, and there was evidence to assure the recommendations had been addressed. Some of the areas in which ongoing attention was needed for the Facility to maintain full compliance with the Settlement Agreement included: ▪ The State Office was reported to have released the Observation Note Audit Procedure on 12/4/13. The Facility reported it had completed all training on 12/18/13. However, the training curriculum and the State procedure were not available. These need to be made available by the next review. ▪ The Facility had a system in place for reporting, and investigating possible abuse and neglect. As noted above with regard to the Facility Self-Assessment, the Facility did not yet have a self-assessment process that produced reliable and valid results, and looked at both the presence as well as quality of efforts to protect individuals from harm. Going forward, the Facility will need to improve these efforts and be continuously vigilant with quality monitoring to ensure that the processes in place stay vigorous, and that there is consistent follow-up on recommendations from investigations to help prevent abuse and neglect from happening in the first place.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D1</td><td>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.</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</td><td>Substantial Compliance</td></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 a document entitled Incident Data, prepared by the Facility at the request of Monitoring Team, the abuse/neglect/exploitation allegations for the past year were:

<table><tr><th></th><th>12/1/13 to 5/31/13</th><th>6/1/13 to 11/30/13</th></tr><tr><td>Total abuse allegations</td><td>77</td><td>84</td></tr><tr><td>Physical</td><td>53</td><td>51</td></tr><tr><td>Verbal/Emotional</td><td>19</td><td>17</td></tr><tr><td>Sexual</td><td>5</td><td>16</td></tr><tr><td>Abuse substantiated</td><td>7</td><td>7</td></tr></table></td><td>Substantial Compliance</td></tr>
</table>

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Physical	7	6
Verbal/Emotional	0	1
Sexual	0	0
Total neglect allegations	**47**	**29**
Neglect substantiated	12	2
Total exploitation allegations	**1**	**0**
Exploitation substantiated	0	0

The numbers of Unusual Incidents investigated over the past year included:

	12/1/13 to 5/31/13	6/1/13 to 11/30/13
Deaths	3	7
Serious Injuries	16	25
Sexual Incidents	4	8
Suicide Threat (credible)	2	3
Unauthorized Departure	16	13
Choking	2	1
Other	3	3

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, revised 11/22/13 staff were required to report abuse, neglect, and exploitation immediately within one hour by phone to DFPS and the Director/Designee. 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 11/22/13, 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: Although not used to assess compliance, based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or

#	Provision	Assessment of Status	Compliance
		exploitation. Metric 2.a.5: Although not used to assess compliance, based on responses to questions about reporting, 10 of 10 (100%) 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 that did not was Sample #D1.10 where the individual's wheelchair tipped over in a vehicle on the way to a medical appointment at 2:23 p.m., but was not reported as possible neglect until 10:27 p.m. the same day. Two staff were present in the vehicle and a call was made to the supervisor in the home when the incident occurred, yet no report of possible neglect was made for eight hours. The investigation confirmed neglect by the staff member who had strapped down the wheelchair. ▪ 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 (Sample #D1.10) for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, none of the UIRs/investigation folders (0%) included recommendations for corrective actions with regard to the late reporting. It is possible that the three staff involved in this matter were focused on making sure the individual was not injured and did not consider the possibility that the event should be considered possible neglect. However, the UIR and DFPS reports should have made clear the need to report such events in a timely manner, and recommended action to prevent recurrence in the future. Based on a review of 12 investigation reports included in Sample #D.2: ▪ Metric 2.a.9: 12 (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. ▪ Metric 2.a.10: 12 (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. Metric 2.a.12: The Facility did have a standardized reporting format. Metric 2.a.13: Based on a review of 27 investigation reports included in Samples #D.1 and #D.2, 27 (100%) contained a copy of the report utilizing the required standardized format and were completed fully.	

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		The sole issue identified in this provision was the lack comment by either DFPS or the Facility on the eight-hour delay in reporting of one incident in which neglect was confirmed. While both DFPS and the Facility should take care to recommend corrective action for failure to report an incident in a timely manner, this single lapse did not mean the Facility failed to substantially comply with this provision. The provision remained in substantial compliance. However, during the next review, this provision will be reviewed, and if any failure on DFPS and/or the Facility's part to recognize the need to address such lapses in reporting or timely reporting is found, then the finding of substantial compliance will be in jeopardy.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to LBSSLC – Incident Management: Abuse, Neglect or Exploitation, dated 11/22/13, 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%) alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation when the alleged perpetrator was identified. Based on a review of 12 Unusual Incident Reports, there were no allegations of wrongdoing by involved staff and no one was removed from duty. 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 when the conclusion of the investigation allowed their return to direct contact duties. The Facility's practice of completing an "Assessment Following Abuse/Neglect Allegation" provided a method for tracking returns, and documenting if there was a reason to return the staff to a different work location. Based on a review of 27 of the documents, it was documented that adequate additional action was taken to protect individuals in 27 cases (100%). For example: ▪ In Sample #D1.15, the alleged perpetrator resigned before action on a finding of abuse was entered. However, the Facility reported the findings to the applicable clinical oversight board. ▪ In other cases, nursing assessments were performed, victim's counseling was provided, level of support was increased, or monitoring was put in place to afford additional protections to the alleged victim. ▪ In unusual incident cases where no allegation of abuse or neglect had been	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		made, additional protections included immediate actions by maintenance to address issues such as temperature controls. The Facility reassigned staff from direct contact with individuals when there were allegations of abuse or neglect, did not return them to duty until the conclusion of investigations, and took reasonable steps to ensure the safety of individuals involved in allegations or in unusual incidents. The Facility remained in substantial compliance with this provision.	
	(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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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	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 any allegations. Correspondents were asked to acknowledge receipt of this information. The Incident Management Coordinator was responsible for tracking this information. His	Substantial Compliance

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	who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	office maintained a notebook where signed statements were kept. Based on a review of 21 individuals' ISPs (Sample #D.4), 20 (95%) 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. The one that was not was Individual #65 (Sample #D4.4), where the ISP included a comment that the Facility would support the individual in making reports, but did not include distribution of the brochure to the LAR or the individual. In interviewing/observing a sample of 10 individuals, three were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. The remaining seven did not have sufficient communication skills to describe what they would do. A review was conducted of five serious incidents/abuse/neglect reported by individuals, their LARs, or others who were significantly involved in their lives as reported by the Facility in response to Document Request #TX-LB-1401-III.19. In five (100%), there was evidence Facility staff provided adequate support to the reporter. The five cases were: Samples #D1.4, #D1.5, #D1.6, #D1.8 and #D2.12. In the ISPs reviewed for this report, over 90% contained evidence that information was provided to the LAR and/or the individual about how to report abuse or neglect. In addition, a sample of reports made by individuals was reviewed, and it appeared that staff had supported them in making the reports. The Facility was in substantial compliance with this provision.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
	(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 define sufficient procedures to audit whether significant injuries are reported for investigation. The procedures specified who would conduct the audits, the size of the semi-annual sample, what documents would be audited, how discovered discrepancies would be reported and what follow-up would be conducted as evidenced by the following: ▪ LBSSLC – Incident Management: Observation Note Audit Procedure dated 4/11/13 (R); ▪ Observation Note Audits in the LBSSLC Executive Safety Committee report, dated 1/9/14, which provided additional details of the audit process; and ▪ Based on a staff report it appeared that the State Office Observation Note Procedure, released 12/4/13, with training completed 12/18/13, provided additional guidance. However, until the Monitoring Team has an opportunity to review the documents, no commentary can be made. The method for drawing the sample was described in the Facility procedure, Observation Note Audit Procedure, which indicated: "Home assignments will be determined by the Incident Management Coordinator and the Lead Campus Coordinator." The Executive Safety Committee minutes, dated 1/9/14, further described the process for conducting audits as follows: "The center has 13-14 auditors in place, comprised of all the Campus Administrators and Campus Coordinators. Each auditor is assigned a home(s) where they will conduct the audits. Every two months, they are each responsible for completing one audit on one resident. This results in a total of 15 audits completed every two months, which translates to 45 audits every 6 months (roughly 22% of the population)." If this method remains in place, every individual should be audited approximately once every two years. The Observation Note Audit Details report for each individual included a summary of trends identified in the audit. For example, audit trends included missing documentation (Sample #D6.2), no apparent nursing assessment when an individual engaged in SIB	Substantial Compliance

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		(Sample #D6.3), and not all peer-to-peer aggression was being reported (Sample #D6.7). In addition, the Executive Safety Committee minutes indicated that auditors were trained to look for any patterns or trends, even if all of the required documentation was in place. The minutes indicated that the only injury pattern found thus far concerned Individual #183, who had several injuries from falls. The data was discussed and an entry was made in the minutes that staff were retrained on the individual's PNMP as a result. The pattern was not reported for further investigation, since there did not appear to be anything suspicious about the falls Audit results were presented at the Executive Safety Committee with data on total notes reviewed, notes with discrepancies, the percentage of discrepancies, and indications of identified trends. At the same Executive Safety Committee, there was presentation and discussion of injuries, allegations, restraints, and peer-to-peer altercations for the past month with indications of frequency by area. Metric 2.i.2: The Facility had conducted audits at least semi-annually, during the preceding 13 months. At the last review, it was noted that a full complement of audits had not been done for a six-month period. For the current six-month period, a full complement had been completed. While the previous six-month period was short of the 20% sample due to changes in the process, enough were in place to indicate that the process was well established, and the process was expected to continue on an ongoing basis. It should be noted that each individual audit covered a period of six months of records prior to the audit, providing a substantial review for each individual. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation. To test sufficiency a sample of ten audit reports were drawn at random from the list of audits conducted between March 2013 and August 2013. Based on the sample, it appeared that auditors were reviewing the specified documentation, noting discrepancies between logs and notes and injury reports, and identifying any trends or patterns that might need attention. Metric 2.i.4: Based on the sample, there were no significant injuries identified by the audit that had not previously been investigated, or reported to the Facility Director, and/or DFPS. It was noted in the Executive Safety Committee minutes that one individual had a pattern of falls that needed review and his IDT did that review. However, as noted above, the IMC should review the procedures and training for auditors, to assure that there is documentation of the requirement for auditors to report any suspicious patterns or discoveries of unreported injuries directly to the Director and/or the DFPS as required.	

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		The Facility has made good progress in implementing an audit procedure. The Facility was in substantial compliance 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 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		substantial compliance finding from the last review stands.	
	(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: ▪ Fifteen out of 15 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. ▪ Fourteen out of 15 (93%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; 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. ▪ Fifteen (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 10 of the investigations, recommendations were needed. In nine of the investigations reviewed, recommendations for corrective action were included. In nine of the investigations (90%), the recommendations were adequate to address the findings of the investigation. It was noted that recommendations were sometimes in both the DFPS report and in the accompanying Facility UIR	Substantial Compliance

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		and sometimes only in the Facility UIR. In one case, Sample #D1.14, neither report contained recommendations. However, the Case Review Checklist did contain appropriate recommendations, and there was evidence that the recommendations had been followed. The Facility should assure that all recommendations are included in the UIR to facilitate tracking. The case that needed recommendations, but did not include them was Sample #D1.10. In this case, the allegation of neglect was not reported for several hours after the incident and was confirmed as neglect. Neither the Facility nor DFPS included a recommendation to retrain staff on the importance of timely reporting, nor did the Case Review Checklist include such a recommendation. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Twelve out of 12 (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. ▪ Eleven out of 12 (92%) were completed within 10 calendar days of the incident, including sign-off by the supervisor or had documentation of a written extension (one). The one that was late and without an extension was Sample #D2.1. ▪ Twelve (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 10 of the investigations reviewed, recommendations for corrective action were included. In two, recommendations were not needed, and in the remaining 10 investigations (100%), the recommendations were adequate to address the findings of the investigation. The Facility remained in substantial compliance with the provision.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each	<u>Metric 3.f.1:</u> 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. <u>Metric 3.f.2:</u> The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u>	Substantial Compliance

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	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.	The following summarizes the results of the review of DFPS investigations:
		▪ Metric 3.f.3: In 15 out of 15 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 15 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.5: In 15 (100%), the name(s) of all witnesses;
		o Metric 3.f.6: In 15 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.7: In 15 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.8: In 15 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o Metric 3.f.9: In 15 (100%), all documents reviewed during the investigation;
		o Metric 3.f.10: In 15 (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 15 (100%), the investigator's findings; and
		o Metric 3.f.12: In 15 (100%), the investigator's reasons for his/her conclusions.
		
		Facility Investigations
		The following summarizes the results of the review of Facility investigations:
		▪ Metric 3.f.13: 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.14: In 12 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In 12 (100%), the name(s) of all witnesses;
		o Metric 3.f.16: In 12 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.17: In 12 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.18: 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.19: In 12 (100%), all documents reviewed during the investigation;	

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		o Metric 3.f.20: 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.21: In 12 (100%), the investigator's findings; and o Metric 3.f.22: In 12 (100%), the investigator's reasons for his/her conclusions. The Facility remained in substantial compliance with this provision.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Metric 3.g.1: The Facility policy and procedures did require that staff supervising the investigations reviewed 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. DFPS Investigations The parties have agreed that due to concerns related to the confidentiality of the DFPS supervisory process, the Monitoring Teams will not review it. As a result, the Monitoring Teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. Facility Investigations Supervisory reviews were conducted at several levels. The IMC and the Director conducted preliminary review of the UIR, marked it up and returned it for corrections, as necessary. The final UIR was reviewed as well, though not marked up and returned as often as the preliminary. For review of DFPS reports, the ADOP, the Unit Director or Department Head, and the Director of Residential Services used a review form, "Case Review Checklist," to provide an avenue for local recommendations to be added to those of DFPS and the UIR investigator. However, these Case Review Checklists were not found in the files of the Facility Only reports submitted for review. For the cases for which DFPS conducted investigations, these checklists together with the reviews of the preliminary UIRs provided assurance that the final UIR was correct and complete. The Supervisory Checklist was added, after all recommendations had been carried out to assure that nothing had been overlooked in the process. Since the Supervisory Checklist came after the final report was entered, it was not being used as the primary tool to assure the UIR was accurate. The following summarizes the results of the review of Facility investigations:	Substantial Compliance

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		Metric 3.g.8: Six of 12 (50%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation as evidenced by the marked-up copies of the preliminary UIRs in the file. These mark-ups occurred on or before the date of the final UIR and were useful in assuring the final product was complete. While every file contained a supervisor's review sheet, dated a month or more after the final report, that sheet rarely included comments directed at correcting or improving the UIR, since those corrections were generally made prior to the final report. The reports that did not include a preliminary copy of the UIR or a copy of a "Case Review Checklist," completed within five days of the UIR were: ▪ Sample #D2.1; ▪ Sample #D2.3; ▪ Sample #D2.7; ▪ Sample #D2.10; and ▪ Sample #D2.12. Metric 3.g.9: In 12 out of 12 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. For 11 of 12, this was evidenced by the inclusion of a signed and dated supervisory review checklist. The one that did not have a completed supervisory sheet was sample #D.2.10, where a blank form was included in the file, due to the fact that the investigation had not been closed. However, LBSSLC used the supervisory sheet as a tool to assure that the final report was complete before closing the file. The preliminary UIR was used to determine if there were edits needed to the investigator's reports, prior to completion. UIRs were marked up as needed and the corresponding changes could be seen in the final UIR. This appeared to be a good system for assuring the accuracy of the UIR. The supervisory sheet served to confirm that the necessary work had been done. 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: There were no investigations noted above (in Sections D.3.e and D.3.f) for which the Monitoring Team identified deficiencies. Metric 3.g.8 did not indicate substantial compliance because the supervisory reviews or alternative/equivalent reviews were not completed within five days of the final UIRs, it was clear that the Facility was relying on the use of the preliminary UIR to address corrections to the reports. That five files did not include copies of the preliminaries may have meant that there were no corrections needed in those reports. The fact that the	

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		Monitoring Team did not find issues with those reports supported this possibility. The Facility remained in substantial compliance for this review. However, the Facility needs to clarify its procedures and document how supervisory reviews will be conducted, either before or within five days of the final UIR, or the Facility needs to complete the supervisory checklist within five days of the final UIRs for the next review.	
	(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 did meet the requirements outlined in Section D.3.f. The Facility was in substantial compliance with this provision.	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. The Facility maintained a "Pending Recommendation Log" to track investigation recommendations and to assure completion. The Log was discussed daily at the IMRT meetings. Any recommendation that could not be completed on time required an extension from the Director. Metric D.3.i.3: For four out of four of the investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. Those four were Samples #D1.5, #D1.8, #D1.10, and #D1.11. Based on a review of a subsample of five investigations for which recommendations for programmatic action were made (as listed for Sample #D.5 in the Documents Reviewed list), the following was found: ▪ Metric D.3.i.4: For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. Metric D.3.i.5: For five out of five investigations (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic action (or in cases where it was too early to tell, a plan was in place to measure the impact), or when the outcome was not achieved, the plan was modified. For example, in Sample #D2.12, involving a report of sexual activity between peers, recommendations were made and acted upon to enroll the involved individuals in appropriate classes. This was done and documented. The expected outcome in terms of the behavior of the individuals was to be monitored and ISPs amended by the IDTs through their reviews of the individuals' programs. There also was a corrective action	Substantial Compliance

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		plan in place at the Facility to address similar issues with other individuals, through a variety of steps, including identification of sexually active individuals so that staff would be alert to monitor their behavior. The individuals in Sample #D2.12 were added to that list. In two other cases checks were instituted to assure that the provided training resulted in changes in staff behavior with regard to policing for cigarettes butts and trash at the end of each shift. This provision remains in substantial compliance. To sustain compliance the Facility should continue to document follow-up after recommended changes are made to assure the changes had the desired results.	
	(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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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: Did address the minimum data elements; ▪ Metric D.4.4: Did use appropriate trend analysis procedures; ▪ Metric D.4.5: Did provide a narrative description/explanation of the results and conclusions; and ▪ Metric D.4.6: Did, as appropriate, contain recommendations for corrective actions. The Facility had an Executive Safety Committee in place and charged with reviewing data from a number of sources, including incidents, abuse/neglect, restraints, peer-to-peer	Substantial Compliance

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		aggression, and injuries. In addition to the basic analyses, the committee analyzed data across the various categories to determine which individuals and which locations were responsible for the trends in the data. This resulted in a list of individuals with the most allegations, injuries, restraints, peer-to-peer issues, and staff injuries over a six-month period. Such analysis provided a data-based method for targeting individuals for additional support from their IDTs, as well as additional inquiry into the causes behind the data. As a result, the Committee was able to call attention to the individuals with the most issues and alert their IDTs to take action. During the meeting observed during the site visit, discussions had progressed beyond the requirements of this provision to comparisons of risk levels as determined on Individual Risk Rating forms with the list of individuals experiencing falls. This was a very positive practice that showed a commitment to protection from harm. It was noted that some people with low risk were having high numbers of falls, leading to the determination that a review the IRRFs was needed for some individuals and an increase in their risk levels was likely necessary. The Executive Safety Committee had developed into a dynamic group, actively engaged in analyzing data and making and overseeing recommendations for improvements. 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 developed. For example, as reported in the 11/21/13 presentation of the Executive Safety Committee, an increase in peer-to-peer aggression resulted in steps being recommended and assigned to staff for follow-up, resulting in a CAP (i.e., Serious Injuries Related to Peer-to-Peer Aggression, approved 12/2/13). Metric D.4.8: As appropriate, corrective action plans were developed both for specific individuals and at a systemic level. Most plans were follow-ups to discussion of data. For example, the Safety Officer reviewed Residence 513 in response to an identified upturn in falls. He reported back to the Committee that the environment had been reviewed, identified environmental issues were corrected, and one individual was identified with poorly fitting shoes. She was taken for evaluation and remedial inserts were placed in her shoes to give a better fit. Metric D.4.9: The trend reports and/or minutes did show that corrective action plans were implemented and tracked to completion as noted above with the actions related to falls. Metric D.4.10: The report/minutes did review, as appropriate, the effectiveness of previous corrective action plans.	

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		Based on a review of resulting action plans and documentation related to implementation: ▪ Metric D.4.11: Three out of three action plans (100%) 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 three out of three of the action plans reviewed (100%), the plan had been timely and thoroughly implemented. ▪ Metric D.4.13: For three out of three action plans (100%), 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 had a system in place for tracking and trending across the categories listed in this provision, and for analyzing that data by individual and by home across several categories. The Executive Safety Committee was actively reviewing the data monthly and making recommendations for corrections to the QA/QI Council, to disciplines, and to individual teams, and monitoring the results. Both formal CAPs and individual or home-specific actions had emerged from their work. While continuous work will be needed to assure that actions taken produce the desired results, the system was in place to organize and monitor those actions. As a result the Facility was found to be in substantial compliance with this provision.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the 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 parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

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 – Review Processes: Quality Assurance Process/Plan, 12/5/13 (R); o LBSSLC Quality Assurance Matrix, dated 10/10/13; o Data Inventory, dated 11/6/13; o LBSSLC Corrective Action Plan (CAP) Process, undated; o LBSSLC Correction Action Plan Tracking, dated 12/6/13; o Administrative/Outcome Measures (State), undated; o Administrative Outcome Measures (Facility), dated 10/30/13 o List of Current Spreadsheets, undated; o Presentation Book for Section E; o LBSSLC Self-Assessment Section E, dated 12/20/13; o LBSSLC Action Plans Section E, dated 12/20/13; o Quality Assurance/Quality Improvement (QA/QI) Council Meetings: dated 6/6/13, 6/24/13, 7/9/13, 7/30/13, 8/23/13, 9/6/13, 9/26/13, 10/10/13, 10/15/13, and 10/29/13; o LBSSLC Executive Safety Committee Meetings, dated 7/11/13, 8/26/13, 9/27/13, 10/6/13, and 11/25/13; o Monitoring tools associated with the Quality Enhancement Plan; 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: Sections C, F, J, N, and U. ▪ **Interviews with**: o Libby Allen, Facility Director; o Robin Seale, Assistant Director of Programs; o Rodney McWilliams, Incident Management Coordinator; o Dawn Ripley, Director of Quality Assurance; o Program Quality Monitors and Quality Assurance Nurses; and o Informal interviews/conversations with staff and individuals. ▪ **Observations of**: o The Quality Assurance/Quality Improvement Council, on 1/7/14; o Presentation on the Corrective Action Plan for Infection Control, on 1/7/14; o Unit I and II Morning Meeting, on 1/8/14; o Incident Management Meeting, on 1/8/14; o Executive Safety Committee, on 1/8/14; o Visits to Residences #520, #517, #515, #528, #527 and #526; and o Visits to the large and small workshops.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 12/20/13. 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 E, in conducting its self-assessment: ▪ The Facility did not use the results of applying the QA monitoring tool for the Self-Assessment, though there was evidence in the files that the QA tool was in use. The tool did not appear to be a useful gauge of compliance. For example, the QA tool did not provide for monitoring the QA Plan, or the matrix and data inventory for accuracy and updating. The tool did not collect any information about when the tools were updated, and whether they were completed according to the matrix. This report and the Monitoring Teams' protocol for this section provide information about what the Facility should review through its monitoring to accurately assess the status of compliance. ▪ The Facility used other relevant data sources, such as reviewing procedures, meeting minutes, and corrective action plan logs to self-assess for compliance. 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 present data employing charts or graphs to show progress toward compliance for Section E. 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 QA/QI Council minutes to determine regular review of data/analysis with recommendations for corrective action made, as needed." To do this, the QA Director 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, but did include some indicators. For example, with regard to Section E.4, the closing of one CAP concerning Medicare Part D Rejection was noted with the information that the rejection rate was below 2%, which supported the effectiveness of the CAP. There was information related to Section E.5 that one of 20 CAPs was data-based, which would have been a useful indicator of quality, if there had been a definition in a monitoring tool to indicate what data-based meant in this context. ▪ The Facility rated itself as being in compliance with one of the subsections of Section E (i.e., Section E.3). This was consistent with the Monitoring Team's findings. ▪ The Facility's data did identify some areas in need of improvement. For example, the need for the key indicator data to track with sufficient particularity and to identify trends across a variety of areas; the need for two outstanding CAPs to be submitted to QA/QI for review; and the need for CAPs to be data-based.
	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 some notable progress with regard to Section E, including:

	▪ The Executive Safety Committee had continued to review data on incidents, injuries, and restraints, and was 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. Data were analyzed by individual across multiple data sources to produce lists of those individuals with the most issues. This Committee was composed of executive staff, including the Quality Assurance Director. As a result, the Committee could direct immediate action toward solving problems and they did. When the actions taken did not resolve an issue, the issue was referred to the QA/QI Council for additional consideration and action. ▪ Some key indicators of performance, called Administrative Outcome Measures, were in place, and data collection had begun in September 2013, with October 2013 data being considered the baseline. ▪ The Monitoring Team noticed discussions about quality and about accuracy of data not only with regard to Section E, but also throughout the Facility, suggesting a Facility-wide investment in quality. ▪ Revisions were made to the QA Plan that addressed issues identified during the last visit. Specifically, the matrix had been improved and appended, the data inventory had been established and appended, and key indicators of Facility performance had been appended. ▪ The number and sophistication of CAPs had increased. For example, there was a CAP on peer-to-peer sexual incidents that included new approaches to teaching identified individuals about relationships and appropriate behavior in public, as well as security considerations. The CAP was cross-disciplinary and data driven, and it was an important, although not an easy issue to address. ▪ Staff had been added to supplement data analysis, nursing quality assurance, and the administrative functions of the department. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ Much work was done on establishing key indicators of progress across the system, and the Facility had begun to collect data on those indicators, and the data were included in the data inventory. However, definitions for key terms and methodologies for collecting the data need to be established. Benchmarks and goals for key indicators need to be established, and steps need to be put in place to assure that the data collected are accurate and reliable measures of progress. Over time, additional key indicators will need to be added for a comprehensive list to exist. However, as the Facility had decided to do, it is important to start with a reasonable number, and build the system over time. When data identify issues, action will need to be taken to address them. ▪ The matrix needs to be further updated and designed to facilitate accurate tracking of the names and numbers of monitoring tools and whether they have been used as anticipated. ▪ While there was progress in the development of CAPs, more work was needed to encourage the development of CAPs that result from data analyses, and include baseline and outcome measures in measurable terms. Other than through the work of the Executive Safety Committee, strong analysis of data was largely lacking. ▪ There was progress in some sections in avoiding reliance on single overall compliance scores. This progress needs to continue by drawing attention to the specific data that indicate a need for action or for 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.	<u>State QA policy</u> As was indicated in the last report, 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. The Monitoring Teams' comments on the State Office policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated two years ago, edits may be needed. State Office should consider this. <u>Facility QA policies</u> Facility policies and procedures related to quality assurance (as listed in Documents Reviewed) were examined and found to support/implement the State QA Policies. <u>QA data list/inventory of data</u> The Facility maintained a data 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. The inventory included a list of current spreadsheets and reports generated from those spreadsheets, and the Quality Assurance Section of the inventory listed all the monitoring tools in use except for sections O, P, and R, which were listed in the spreadsheets list. The names of tools in the matrix should match the names of tools in the data inventory. In both locations, the name of the tool should include the last date modified to make the tools distinguishable from previous versions. The data list/inventory included data on key indicators (outcome and process) of performance that the QA/QI Council selected to track priorities. The Facility's list of key indicators was tied to six overarching Administrative Outcome Measures, and included some, but not all of the indicators recommended on the State list as well as some locally generated indicators. As is discussed further below, over time, additional key indicators will need to be added for a comprehensive list to exist. However, as the Facility had decided to do, it is important to start with a reasonable number, and build the system over time. The data list/inventory included data from: ▪ Settlement Agreement self-monitoring tools: ▪ Disciplines/departments; ▪ Areas of Care; ▪ Protections; ▪ Supports; and	Noncompliance

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		▪ Services. Most data in the data inventory was tied to the State's AVATAR system. While the Facility could draw down data from the State system and create local databases, those data could be sorted according to the program areas; living units; work shifts; and individuals, since that was part of the design of the system. Data in spreadsheets or locally established databases, not tied to the State system, would not necessarily allow for the same sorting. All data in the inventory included a brief description of the data and the source of the data. The data inventory was current according to Facility policy, having been updated on 10/10/13. The Facility Policy required review and updating of the data inventory periodically, and revisions as modifications were made to monitoring at the Facility. The policy did not require an update at six-month intervals, but the process at the Facility appeared to be that the inventory was modified as changes in data collection and monitoring occurred, and the dates of revision were maintained. This should include documentation of a review at least every six months to determine if any changes are needed. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was current as evidenced by the date of revision. Specifically, the QA plan narrative had been reviewed and revised, as appropriate, within the last 12 months. The QA plan narrative was generally complete in that it included the elements outlined below, with one exception. More specifically, the QA Plan described the QA program, including at a minimum: ▪ A description of the purpose of the QA program; ▪ The organizational structure of the QA process (including individual roles and responsibilities); ▪ The data inventory; ▪ QA matrix; ▪ Key indicators of performance; ▪ A description of how data are summarized and analyzed; ▪ The role of other departments in QA (including QA Department and discipline department collaboration/meetings); ▪ Workgroups or quality assurance related committees, but as noted below, this description was not comprehensive, because it left out the Executive Safety Committee; ▪ The QA report; ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process; and ▪ A description of how corrective actions/CAPs are tracked. The QA Plan did not describe the Executive Safety Committee and its relationship to the	

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		QA/QI Council. That committee had developed as a forum for review and analysis of data from many varied sources, and produced reports graphing data over time and in comparison to other related data streams. For example, there were charts showing the individuals with the highest rates of injuries, allegations, restraints, peer-to-peer aggression, and staff injuries over a six-month period. The resulting list was a powerful tool to assist in decisions about where to prioritize action. This committee appeared to be conducting serious, in-depth analysis of data, directing actions to address discovered issues, and reporting its work to the QA/QI Council on a monthly basis. Only when actions directed by the Executive Safety Committee were not effective was it necessary for the Council to become involved in approving Corrective Action Plans or other measures. The Facility should add this important component to the description of its quality assurance related committees. <u>QA Plan Matrix</u>: 1. Key Indicators (process and outcome) for each Settlement Agreement section: ▪ For the 20 sections of the Settlement Agreement, a set of key indicators was available for 20 of the 20 sections, though they were included in the matrix under six major administrative outcomes, rather than by section of the Settlement Agreement. The Facility had clearly done a tremendous amount of work to develop a set of key indicators. The process the Facility used made sense in terms of reviewing what State Office had sent, selecting some key indicators from that list, and developing some of their own. This was a good start, but in terms of the adequacy of the list, it remained a work in progress. As discussed with the Facility Director, while the Monitoring Team was on site, definitions for key terms and methodologies for collecting the data need to be established. Benchmarks and goals for key indicators need to be established, and steps need to be put in place to assure that the data collected are accurate and reliable measures of progress. In order for an adequate set of key indicators to exist, these elements needed to be present. ▪ Of these 20, both process and/or outcome indicators were identified for 20 of the sections. Over time, additional key indicators will need to be added for a comprehensive list to exist. However, as the Facility had decided to do, it is important to start with a reasonable number, and build the system over time. ▪ Of these 20, in 20 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. However, as noted above, more work was needed for a comprehensive set of key indicators to exist. 2. Self-monitoring tools for all Settlement Agreement provisions: The QA plan matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the	

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		Settlement Agreement. Copies of tools were not provided for Sections I, O, P, and S. However, they were listed in the matrix as having tools, and there were data summaries and reports for O, P, and S that suggested at least some tool was being used. Section I was listed on the matrix with Section F, and there was a section of the Annual ISP Meeting Preparation Checklist (i.e., dated 9/17/13) that addressed Risk (Part 1, A-H.) Sections O and P listed a Universal HT Monitoring Tool in the matrix. However, no tool with that label was in the collection of tools in IV.3.c of the document request. The self-monitoring tools, themselves, did not identify the frequency of monitoring, and the persons responsible for monitoring. These were identified in the matrix. 3. <u>All Data Collected by QA Department</u>: All data that QA staff members collected were listed on the matrix. While the Facility relied on additional information from a variety of sources to supplement QA data in the Facility's self-assessment, the QA staff members did not always collect the supplemental data. For example, for Section D, the Incident Management Coordinator reviewed the Alleged Perpetrator Tracking Report to assure alleged perpetrators were not in direct contact with individuals pending a completed investigation in addition to reviewing the monitoring data for compliance with the requirements in Section D.2.b. 4. <u>All Items in QA Plan Matrix Also Appear in the QA Data Inventory</u>: All of the items in the QA plan matrix also appeared in the QA data list/inventory. 5. <u>All data in QA plan matrix were submitted and received</u>: The Monitoring Team reviewed data for the months of September and October or for the last quarter for those sections monitoring quarterly. Data were reviewed by section rather than by tool, since the matrix was difficult to follow with regard to the number of tools for some sections and the correct names for the tools. However, considering data submitted related to each section in the QA plan matrix for the 20 sections of the Settlement Agreement, data were submitted/collected/received by the QA Department as follows: ▪ The discipline leads for the sections that did not appear to have provided data to the QA Department were Sections C, K, and R, which may have had data but did not submit them due to the absence of a Program Compliance Monitor in Quality Assurance, and I, which did not have a tool in use for this monitoring period. ▪ The sections that submitted data for both September and October were sections F, G, H, L, J, and M; ▪ The sections that submitted data for one of the two months were sections D, E, N, O, P, Q, S, T, U, and V. Of the 20 sections in the QA Plan Matrix, six sections (30%) were	

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		submitted/collected/received by the QA Department for the September and October reporting periods or for the quarter if scheduled for quarterly submissions. 6. Reviewed/analyzed: Of the 20 sections in the QA plan matrix, six (30%) were documented to show some level of review or analysis by the QA Department and/or the department section leads for the last two reporting cycles for the listed tools (e.g., monthly, quarterly). The ones that did were: F, G, H, L, J, and M. Since the rest did not submit data for both September and October, they were not counted as complying, though all but four (O, R, I, and K) did provide evidence that analysis was done by either the discipline and/or the QA Department for the months they submitted data. A large part of the problem was the temporary absence of the PCM and the QA Nurse that provided and/or documented the analysis for several sections. While many of the reviews summarized monitoring data, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed. Implement the QA Plan as written: Due to the fact that the Facility was in the initial stages of implementing the key indicators, the Monitoring Team did not attempt to quantify the following metric for this report: Of the ___components of the QA plan narrative and QA plan matrix, the Facility implemented ___%. QA Staff Assist Disciplines/Departments in Analysis of Data Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, that there was documentation that it was not needed. For the 19 sections of the Settlement Agreement (Section E excluded), for 12 there was documentation indicating that QA staff had assisted the section leads with analysis in some respect. However, as noted above, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed. For those sections without documentation of assistance, there was no documentation of the reasons that assistance was not needed. The sections that did not appear to have been assisted with data analysis were: Sections F, G, H, L, I, J, and V, and there was no documentation to indicate why assistance was not needed. Self-Monitoring Tools/activities for all sections of the Settlement Agreement: Content/validity: Of the self-monitoring tools for the eight sections of the Settlement Agreement in the sample (C, D, E, F, J, T, U and V): (a) the content of five (63%) included indicators relevant to compliance with the Settlement Agreement section. Those that did	

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		not were: ▪ Section E: minimal information was collected on the form. For example, for Section E.1, there was no information about the QA plan and whether it had been or needed to be revised; the matrix and whether the listed tools were up-to-date, had guidelines, and had been completed as indicated; and there was no information about the data inventory, whether it was up-to-date and complete or in need of revision. ▪ Section F: information in the listed tool could not be linked to the self-assessment. In addition, although this tool 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 (e.g., Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate?). For many other indicators, terms and/or standards were not defined. As a result, it was not clear that quality would be assessed consistently [e.g., Did the IHCP (for all medium and high ratings) reflect all appropriate services and supports to reduce the impact of risk?]; and ▪ Section U: indicators that were included were relevant to compliance, but additional indicators likely needed to be added to the tool. For example, it was not clear that the data collected through the use of this tool was consistently used in the Self-Assessment, and/or which monitoring tool was used to collect some of the data for the Facility's Self-Assessment activities. For example, for Section U.1, data was provided in the Self-Assessment regarding whether teams discussed the individuals' level of intellectual disability, psychiatric conditions, and communication abilities from a review of 20 ISPs. It was unclear what monitoring tool was used to collect this information, because no indicators related to these components of the ISP were included on the Section U monitoring tool. (b) Two (25%) were reviewed within the past six months, and revised. Those two were the tools for section F and J. <u>Adequate instructions</u> Of the self-monitoring tools for the eight sections of the Settlement Agreement in the sample, two (25%) had adequate instructions for the user. Those two were Sections C and D. Additional information on the other six sections in the sample as well as the sections that were not part of the sample are included under the Facility Self-Assessment headings in this report. <u>Implement monitoring tools per the QA Plan</u> Since the last onsite review, of the self-monitoring tools for eight sampled sections of the Settlement Agreement, two (i.e., Sections U and V) (25%) were implemented as per the QA	

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		plan (e.g., number, schedule, person responsible, inter-observer agreement). Those that were not included: ▪ Section C: no inter-observer agreement, and schedule not followed due to turnover in PCM position; ▪ Section D: schedule not followed due to turnover in PCM position; ▪ Section E: no information beyond July 2013; ▪ Section F: no graphs/evidence of completion for October due to database issues; ▪ Section J: no PCM audit in October due to PCM position turnover; and ▪ Section T: the matrix listed only the PCM as responsible for auditing, yet there was inter-rater reliability data that indicated the department had also monitored; PCM did not monitor two visits in July/Sept quarter due to inability to travel to the Dallas area. <u>QA staff and department staff review of results</u> Since the last onsite review, of the eight sections of the Settlement Agreement included in the sample, there was documentation that the implementation of self-monitoring was reviewed with the department staff at least once each quarter for six (75%) of the sections. The two that were not were Section E where the Quality Assurance Director and her staff met, but only once; and Section V, where the Unified Records Coordinator was responsible for the audits and there was no evidence of meetings with anyone. At the next monitoring, the Facility (Quality Assurance Director) 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 was 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	

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		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 progress had been made in the plan narrative, data inventory, and in providing an initial list of key indicators of performance, the Facility was not in substantial compliance with Section E.1. Some of the issues that required attention included: the matrix was not up-to-date, so it was not clear how inter-rater reliability would be achieved in some sections, such as Section C, where QA did one tool and the Director of Behavioral Services did a separate and different tool; further work was needed to finalize a set of key indicators; and tools did not always have adequate indicators and/or instructions. To move forward the Facility should concentrate efforts on presenting the information included in the last paragraph above.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	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: ▪ Summarized, ▪ 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 should 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 that results in the identification of common issues and/or underlying causes of those trends or issues. While most sections summarized data for quarterly reports to QA/QI Council, and others included graphs of data by month for the elements of the monitoring tool, none graphed data over six to twelve months or according to (a) through (g) above. Regular Meetings Between Discipline Department and QA Staff For a sample of five sections, the minutes of the most recent two meetings between the discipline/department and the QA staff were selected for review, including: ▪ Section C: 7/23/13 and 9/23/13; ▪ Section F: 10/17/13 and 11/20/13; ▪ Section J: 8/16/13 and 9/17/13; ▪ Section N: 7/23/13 and 9/30/13; and ▪ Section U: 10/15/13 and 11/19/13. Based on a review of the minutes, since the last onsite review, a meeting occurred at least twice for five of the sampled sections (100%) of the Settlement Agreement;	Noncompliance

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		▪ The minutes of these meetings documented that the reviews that occurred in each meeting included the following: o In 0% review of the data inventory and matrix; o In 100% discussion of the data and outcomes; o In 100% review of the conduct of the self-monitoring tools, o In 20% creation/proposal of corrective action plans. Section F discussed a CAP for attendance at ISP meetings. o In 0% review of previous corrective action plans, since there were no previous CAPs. <u>Data were available:</u> ▪ Since the last onsite review, during 10 of the ten (100%) meetings, data were available to facilitate department/discipline analysis of data. <u>Data were reviewed/analyzed</u>: ▪ Since the last onsite review, during 10 of the 10 (100%) meetings, data were reviewed and analyzed. However the analysis involved only the month the data were collected, rather than a trend over time except for section N where some data were analyzed over a period of one year. In addition, as noted with regard to Section E.1, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed. ▪ Since the last onsite review, during one of the 10 (10%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. <u>QA Reports</u> 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 Leads for incorporation into their quarterly reports to the QA/QI Council. The minutes and attachments of QA/QI Council meetings confirmed this. Since the last onsite review, Facility QA reports were created for all of the six (100%) months (June 2013 through December 2013). Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the Settlement Agreement that were presented, none of 20 (0%) contained all of the following components:	

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		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. <u>Facility QA/QI Council</u> <u>Design</u> There was an adequate description of the QA/QI Council in the QA plan/policy narrative. The QA plan/policy narrative listed the Facility Director as chairing the QA/QI 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. <u>Schedule, agenda, attendance</u> Since the last onsite review, the QA/QI Council did meet at least once each month, and in most months twice. Minutes from nine of the nine (100%) QA/QI Council meetings since 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. <u>Data and Analysis Presented</u>: Data and Analysis Presented: Minutes from none of the nine (0%) QA/QI 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 or newly instituted and the sections leads did not report data. However, by September 2013, data reports were beginning to become available on the key indicators. ▪ The data presented were not trended over time in most section presentations. 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 QA/QI Council. Examples included: explanations of discrepancies in injury data as reported by Risk	

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		Management and Incident Management; reasons for the rise in restraints in a particular month; and 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 QA/QI Council included some comments and interpretations, but this was an area that required further expansion. <u>Recommendations and Corrective Action Plans</u>: ▪ In nine of the nine meetings (100%), recommendations were discussed, and CAPs were selected when appropriate to do so and were based on the data presented. However, the CAPs varied with regard to how they were connected to the data. For example: o CAP #1 had three actions all with the expected outcome of Facility contracts complying with DADS SSLC Facility Contracts requirements. It was not clear what the level of compliance was at the start of the CAP or what the level would be (expected outcome) at the conclusion. o CAP #3 had a clear expected outcome of "eradication of communicable infections in individuals residing in building 504," followed by numerous steps all of which appeared to share the same expected outcome. To be data-based, the outcome needed to include the number of individuals with a communicable infection at the start of the CAP and after the plan had been carried out. o CAP #4 had a series of actions with a variety of expected outcomes, such as developing guidelines regarding off-campus co-ed activities with the outcome of supervised off-campus activities provided for applicable individuals. To be data-based, the outcome would need to indicate whether any individuals participated in supervised off-campus activities before the CAP, and how many would be expected to participate once actions were completed. <u>System for generating CAPs:</u> A written description did exist that indicated how CAPs were generated, but as noted below, some concerns were identified with the description. The description, "LbSSLC Corrective Action Plan (CAP) Process," was included in the Presentation Book for this section. 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, nor were there cautions that evaluation should not be by percentages alone, because of the fact that percentages do not always tell the story that needs to be told (however, none of the current CAPs appeared to be based on an arbitrary number).	

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		▪ No instructions about how to connect the CAP to the data being reviewed. CAP development: There was some confusion over the number of CAPs. The Facility Self-Assessment indicated that when Facility staff reviewed the list on 12/5/13, there were 20 active CAPs. However, there appeared to be nine CAPs on the list dated 12/6/13, and presented to the Monitoring Team. In discussion with the Quality Assurance Director, it was not clear whether to count the QA/QI approval dates, the issue dates, or something else to determine the number. For purposes of this report, the number of issues with approval dates was used. When considering the full set of nine CAPs, nine (100%) appeared to have been chosen following the current written description policy or procedure. However, as indicated in the last paragraph, the description did not include how to evaluate indicators. The list of CAPs, identified by issue and date, included: 1. Facility Support Performance Indicators (FSPI) Contract Management Module, approved 9/6/13; 2. FSPI Fleet Management Module, approved 12/4/13; 3. Building 504 Infection Control, approved 10/4/13 and 12/11/13; 4. Prevention of Peer-to-Peer Sexual Incidents, approved 10/15/13; 5. Fire Marshall Inspection, approved 10/29/13; 6. ISP Attendance for DSP [Direct Support Professional], LAR [Legally Authorized Representative] and the Individual below 90%, approved 12/2/13; 7. Serious Injuries Related to Peer-to-Peer Aggression, approved 12/2/13; 8. Inconsistent Improvement of Nursing Annual Assessments being submitted 10 days prior to ISP over the past six months, approved 12/2/13; and 9. Inconsistent improvement of self-administration of Medication assessment being submitted 10 days prior to ISPs over the past six months, approved 12/2/13. Content of each CAP: Of the nine CAPs the Monitoring Team reviewed, nine (100%) appeared to address the specific problem for which they were created. CAPs contained all necessary components: Based on a sample of nine CAPs, which represented 100% of the total of nine CAPs: ▪ Nine (100%) included the actions to be taken to remedy and/or prevent the reoccurrence; ▪ None (0%) included the anticipated outcome of each action step; ▪ Nine (100%) included the person(s) responsible; and ▪ Nine (100%) included the time frame in which each action step must occur. The Facility was found to be in noncompliance with this provision of the Settlement Agreement. There had been progress on the developing CAPs (from three in the last reporting period to nine in the current one), basing CAPs on data, and targeting issues for	

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		CAPs that were complex and required multi-disciplinary solutions (e.g., the CAPs on infection control and peer-to-peer sexual incidents). Progress also included the beginning of the inclusion of key indicator data at QA/QI Council meetings (since September 2013). However, more work was needed to present data from QA monitoring over time, to analyze it by such factors as living units, to target issues with individuals that have been identified as resistant to IDT or other interventions, and to provide clearer descriptions of how to select CAPs in the CAP process document.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for two consecutive reviews for this policy-related provision. The substantial compliance finding stands.	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.	For purposes of this review, CAP #3 in the list of CAPs in Section E.2, was treated as a completed CAP, since it appeared that what remained were on-going activities or transference of the concepts developed in this CAP to additional homes as the need arose. However, to be clear, the Facility had marked it as completed, and then rescinded that decision to continue to monitor the use of the process developed through the CAP. No other completed CAPs were included in the tracking, although there was evidence in the Self-Assessment and in other documents that there had been CAPs completed during the past six months. Implementation of CAPs: To determine if CAPs were implemented timely, the steps within each CAP were reviewed to determine if the step was completed timely, or if not, action had been taken to correct any problem. Based on a sample of one completed CAP and eight in process CAPs, nine (100%) were implemented and five (56%) of those were implemented in a timely manner. Those that were not timely included: ▪ CAPs #4, #5, #6, and #7, where due dates for steps had passed without an entry in the tracking sheet to indicate the problem; and ▪ CAPs #6, #7, and #8 had due dates prior to the date of approval by the QA/QI Council. While this might mean that the plan was underway prior to approval and then accepted by Council, there needed to be a note of explanation on the tracking sheet. Tracking CAP status: There was a system for tracking the status of CAPs as evidenced by the form in use. Of the nine CAPs the Facility was tracking, for three (33%) the tracking sheet indicated the status of the CAP and any action taken if a CAP or step within a CAP had not been implemented. Those three were CAPs #1, #3 and #5. 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	Noncompliance

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		onsite review; and ▪ Did present this information to QA/QI Council at least quarterly. Performance on the above indicators was not at the 90% level. As a result, the Facility was not in substantial compliance. Including dates that comments were entered in the tracking sheet would help to clarify when actions were taken or steps concluded, and make it possible to determine timeliness of actions.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	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. While the tracking sheet included space to enter the timeframe for monitoring corrective action and space for a re-monitoring score/information, these sections were not filled out. Since a list of completed plans was not presented, it was not possible to ascertain whether information might have been recorded for some completed plans. <u>Evaluate effectiveness of CAPs</u>, <u>including outcomes and timely completion</u>: For none out of the one CAP (0%) designated as completed (CAP #3), documentation showed review of their effectiveness (i.e., outcomes). While it appeared from a presentation about this CAP that members of the Monitoring Team attended that some positive results might have been realized, they were not reflected in the tracking of the CAP. For example, outcomes related to reductions in infections, or increased staff knowledge about and/or conformance to infection control procedures would be examples of measures that would speak to the success of the CAP. <u>CAPs are modified when needed</u>: Since expected outcomes were not expressed as baselines and targets, it was difficult to evaluate whether modifications were done as needed. Of the five CAPs that appeared to need modification, four (80%) had been modified. ▪ CAP #2 had been modified. The CAP tracking showed a plan for FSPI Fleet Management had been approved on 9/6/13, had not produced results by its target date, and was modified on 12/4/13 to reflect a revised process; ▪ CAP #3 had a number of modifications to actions to add a home or to add steps; ▪ CAP #4 eliminated some steps once it was determined locks could not be placed in certain locations; ▪ CAP #5 modified a target date in response to a request for an extension; and ▪ CAP #6 appeared to need modifications since due dates had passed with no indications if the actions had been taken, but no modifications were noted. <u>Modifications/results were discussed at QA/QI Council</u>. Based on a sample of one completed CAP and eight in process CAPs, all (100%) had been	Noncompliance

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		discussed at QA/QI Council. Modifications were implemented as written. For none out of four (0%) modified CAPs, evidence was present to show the due dates had been met or an explanation was provided for any delays. For none out of the four (0%) modified CAPs, evidence was present to show that all the steps of the CAP had been implemented as written. The Facility was not in substantial compliance 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 004.2: Individual Support Plan (ISP) Process (Integrated Protections, Service, Treatments, and Supports) with attachments, 11/21/13; o DADS Policy #006.3: At Risk Individuals, dated 12/7/12; o LBSSLC Procedure entitled: ISP Process – Integrated Protections, Services, Treatments, and Supports, revised 12/5/13; o Most Recent ISP Dates, Dates ISPs were Filed and Previous ISP, undated; o Data on ISP timeliness, for 11/1/12 through 10/30/13; o Assessment data report, for 11/1/12 through 10/31/13; o Team member participation data report, for 11/1/12 through 10/31/13; o Corrective Action Plan for ISP attendance, and related forms; o List of individuals admitted over last six months, including date of admission and date of initial ISP meeting, for 5/15/13 to 11/15/13; o Individual Support Plan Annual Assessments and Attendance Spreadsheets for ISPs Facility provided in response to pre-review document request; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, monthly reviews, ISP Preparation Meeting documentation, and documentation of training for direct support professionals on PNMPs, PBSPs, SAPs, Individual Activity Cards, and ISP for: Individual #97, Individual #20, Individual #7, Individual #109, Individual #240, Individual #3, Individual #214, Individual #315, Individual #21, and Individual #139; o List of QIDP trainings completed on 10/8/13, 10/18/13, and 10/31/13; o QIDP Training Agenda and materials related to Individualized Living Options Action Plans, dated 10/18/13; o Last 10 monitoring tools the QIDP Department completed, various dates; o Last 10 monitoring tools the QA Department completed for Section F, various dates; 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 Annual ISP Meeting Preparation Checklist, revised 9/17/13; o Facilitation Skills Performance Tool, undated; o Q Construction Facilitation Competency OJT [On-the-Job Training] Assessments, updated 1/17/14; o Q Construction Facilitation Competency OJT Assessments, undated, but scanned 12/9/13; o ISP Attendance Data, July to December 2013;

	○ ISP Assessment Data, July to December 2013; ○ ISP Concerns Tracking, scanned 1/9/14; ○ ISP Process – Integrated Services, Treatments, and Supports: Summary for Direct Support Professionals; ○ QIDP Current Assignments and Number of Individuals on Their Caseload, undated; ○ ISP/IRRF Tracking, for ISP meetings held between 5/1/13 and 10/30/13; ○ Individual Support Plan In-Service Tracking Tool, for ISPs held between 6/25/13 and 10/30/13; ○ Provision Action Information, updated 12/17/13; ○ Self-Assessment for Section F, updated 12/20/13; ○ Action Plans: Section F, updated 12/17/13; and ○ Presentation Book for Section F. ▪ **Interviews with**: ○ Sandra Kennedy, QIDP Coordinator; Christina De Los Santos, QIDP Educator; Marc Lopez, System Analyst, and Autumn Warfel, ISP Technician. ▪ **Observations of**: ○ ISP Meeting for Individual #178, on 1/7/14; ○ ISP Meeting for Individual #264 on 1/8/14; and ○ ISP Meeting for Individual #161, on 1/9/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 12/20/13. 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, as well as interviews with staff, and review of other documentation: ○ The Facility was using the audit tool entitled: Annual ISP Meeting Preparation Checklist, dated 9/17/13. Documentation submitted also included the tool entitled: Settlement Agreement Cross Referenced with ICF-MR Standards – Section F: Integrated Protections, Services, Treatments and Supports, revised August 2010. However, it appeared this tool was being phased out. The Facility also was using an audit tool entitled: Direct Support Professional ISP Competency Monitoring Tool, implemented 10/18/13. ○ Of significant concern, there was little correlation between the auditing tool Facility staff indicated was currently in use (i.e., the Annual ISP Meeting Preparation Checklist, dated 9/17/13) and the information included in the Facility's Self- Assessment. Except for a few indicators in the Self- Assessment, most of the information included in the Self-Assessment could not be linked directly to an indicator on the monitoring tool. It was unclear from where most of the data came. This raised the question of how the information for the Self-Assessment was being collected, as well as how, if at all, the information collected through the audit tool was being used to meaningfully drive quality assurance efforts in relation to

	Section F. o Although the Annual ISP Meeting Preparation Checklist tool 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 (e.g., Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate?). For many other indicators, terms and/or standards were not defined. As a result, it was not clear that quality would be assessed consistently [e.g., Did the IHCP (for all medium and high ratings) reflect all appropriate services and supports to reduce the impact of risk?]. o No instructions or guidelines were submitted to define methodology or standards. o As noted in the last report, 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). Based on interview, the ISP Workgroup was in the process of developing audit tools to assess the quality of various assessments. As Facility staff recognized, this process necessitated the involvement of all disciplines. 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 QIDP 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 the Facility's data, inter-rater reliability was over 90%. It was not clear this was accurate, though. For the new tool, the QIDP Coordinator indicated these scores had to be calculated by hand. The chart included in the Self-Assessment related to inter-rater

	reliability could not be interpreted. Inter-rater reliability needs to be calculated per question, and the information in the Self-Assessment was based on overall scores for each auditor. In addition, based on review of the Facility's findings in comparison with the Monitoring Team's findings, it appeared that even if the Facility's monitoring results were reliable, they were not valid for many indicators. This is particularly problematic, because if the Facility's Self-Assessment is not accurate, 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 none of the subsections of Section F. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement. Generally, there was some analysis of this data, and identification of steps that either had been taken or were planned. For example, for Section F.1.b, a clear correlation was made between the findings and Corrective Action Plan the QA/QI Council had approved to address specific concerns identified. In other subsections, there was reference to the specific action plans that addressed the concerns the Facility identified. This was a positive improvement to the Self-Assessment.
	Summary of Monitor's Assessment: As noted in the last report, the Facility Director identified the need for a comprehensive approach to improving Individual Support Plans and set up the ISP Workgroup. 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 and implemented for each of these areas. Based on this most recent review, these efforts continued to have a beneficial impact in a number of areas. The Workgroup had continued to meet with a smaller number of participants to allow focus on key issues. Some of the improvements that were noted with the ISP process included: ▪ Although issues continued to exist with regard to teams accurately identifying the need for team members' participation in ISP meetings, attendance of members that the teams had identified as

	"required" had continued to improve. The Facility's data showed where some of the problems were, and some efforts were underway to improve these team members' attendance. For example, the Facility was in the process of implementing a Corrective Action Plan to improve the attendance of individuals, their guardians, and direct support professionals. ▪ ISP meetings were generally being held annually, and individuals newly-admitted to the Facility were having ISP meetings within 30 days of their admission. In addition, in recent months, final ISP documents were being completed within 30 days of the meetings. ▪ The Facility had made progress in its efforts to develop and implement a system to train staff on the necessary components of the ISPs, and track this training. Some of the areas in which focused efforts continued to be needed included: ▪ The Facility recognized that the quality of assessments was an area needing improvement. The ISP Workgroup was in the process of developing a quality check system for the ISP assessments. At the time of the onsite review, discipline leads had been assigned the task of individualizing the Assessment Quality Checklist for their assessments. It was anticipated that once the audit forms were finalized, discipline leads would review the assessments for a sample of four records each month. ▪ Since the last review, the QIDP Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that nine out of 15 QIDPs had been deemed competent using this tool, with one QIDP identified as "needs work," four that had not been assessed, and one vacancy. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation. ▪ 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. ▪ The Facility was using the Integrated Health Care Plan (IHCP) format, which often expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences. ▪ Action plans included more measurable action steps, which was positive, but this was an area in which work was still needed. Although some limited improvement was seen, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, behavior, skills, etc., or maintaining his/her current status). ▪ The Facility recognized this was an area needing improvement, but the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	On November 21, 2013, DADS State Office issued Policy #004.2: Individual Support Plan Process. On 12/5/13, the Facility's Operating Procedure Manual Committee approved a revised LBSSLC Procedure entitled: ISP Process – Integrated Protections, Services, Treatments, and Supports. Comments regarding the State Office policy and Facility procedure are included in the subsections to which they apply. At the time of the Monitoring Team's onsite review, training on the Facility's ISP Process procedure was underway. The Facility's policy/procedure essentially reiterated the State Office policy with little to no additional information to operationalize the State Office policy at the local level. For example, although LBSSLC had some additional procedures in place to train QIDPs, train staff responsible for the implementation of the plans, review draft ISPs, etc., none of these activities were memorialized in Facility procedure. This is an important step to ensure consistency with expectations the Facility had put in place. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly reviews, the individuals' daily schedules, Special Considerations list, ISP Preparation Meeting documentation, and documentation of training for direct support professionals on PNMPs, PBSPs, SAPs, Individual Activity Cards, and ISP as available. The documents the Facility provided included the most recently developed ISPs from each residence on campus, including those for: Individual #97, Individual #20, Individual #7, Individual #109, Individual #240, Individual #3, Individual #214, Individual #315, Individual #21, and Individual #139. 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 assessing each individual, and in developing, monitoring, and	Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ Policy #004.2 in Section II.F.1.b indicated that the QIDP would assist the	Noncompliance

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	revising treatments, services, and supports.	individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. This was reiterated in the Facility's procedure on the ISP Process in Section G.1.b. ▪ The QIDP Coordinator confirmed that QIDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP was the team leader and responsible for ensuring team participation. ▪ With regard to staffing, as was the case during the last review, two QIDP Educators directly supervised the QIDPs. A QIDP Coordinator oversaw the QIDP Department, and an ISP Technician continued to assist with data management, amongst other duties. This administrative structure was in place to assist in providing QIDPs with needed oversight and training. At the time of the review, there were 14 QIDPs and one vacant position. One of two new QIDPs, who would begin New Employee Orientation on 1/16/14, was expected to fill the vacant position. When all 15 QIDPs were in place, one QIDP generally would be assigned to each residence. Based on the current census of 202, this would be an average ratio of 1:14, with a range of 1:11 to 1:17. ▪ Since the Monitoring Team's last review, eight of the 15 QIDPs had been newly hired, and two new offers recently had been made. This represented a turnover rate of over 50% for QIDPs assigned to the residences. When the Monitoring Team asked, the QIDP Department staff explained that there were other positions categorized as QIDPs, including, for example, the Post-Move Monitor, and the Integrated Program Developers. This might result in a lower turnover rate for all QIDP positions at LBSSLC, but the number above reflected the rate for QIDPs assigned to the residences. As the Monitors recently discussed with State Office staff, the ongoing high turnover rates for QIDPs assigned to the residences makes it difficult to achieve the needed changes with ISPs due to the constant need to train new staff. Although it is positive that QIDPs often move on to other positions within the Facility, it will be important to identify ways to extend the tenure of staff in the QIDP positions. ▪ The Facility had Q Mentors/Buddies. QIDPs were paired with one another to provide support in a number of ways, such as taking typewritten notes at ISP meetings, and covering for one another so that QIDPs could spend an uninterrupted day drafting the final ISP document. QIDP coverage also was discussed each morning at the Incident Management meeting. ▪ As is discussed in further detail with regard to Section F.2.e, on 11/6/13 and 11/7/13, QIDPs underwent a revised version of Q Construction training with a focus on facilitation skills. A review of the PowerPoint slides used for the training showed that it included valuable information about the role of the facilitator and the skills necessary to facilitate. Based on information the Facility provided, each QIDP involved in the training passed the written test. As is	

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		discussed in further detail below, competency in meeting facilitation also was being assessed through observations of ISP meetings. ▪ During the week of the review, the Monitoring Team observed three 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. QIDPs generally kept the teams focused on the agenda. o Although further improvement was needed, the QIDPs and Nurse Case Managers included valuable information in the draft ISPs and IRRFs, respectively. ▪ The QIDPs had provided the teams with draft ISPs. This appeared to assist in facilitating the discussion. As noted in the last report, recommendations from various assessments were included 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 all recommendations are included, and 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. 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 QIDP 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 QIDP to take typewritten notes during the meetings helped ensure that important discussion was documented, while still allowing the other QIDP to facilitate the meeting. o Efforts were made to elicit information from all team members. However, not all team members participated to the extent they should have. 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 discussions about a variety of the protections, supports, and services. Although it appeared	

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		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 sometimes discussed action plans in some detail, particularly some of the strategies that were in place or would be put in place to address risks. Unfortunately, this was not consistently evident in the ISP documents reviewed. o Based on observations, it appeared that team members were coming more prepared to the meetings. ▪ 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. However, 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. Based on observations of 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, QIDPs 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. Since the last review, the QIDP Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that nine out of 15 QIDPs had been deemed competent using this tool, with one QIDP identified as "needs work," four that had not been assessed, and one vacancy. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation. A number of problems were noted with the tool, including but not limited to: 1) numerous facilitation skills were missing from the list, including a number of skills that the Facility had identified in the training provided to QIDPs in November 2013 (e.g., just as one of many	

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		examples, the QIDP's ability to facilitate discussion amongst team members with the result of the development of integrated services and supports was not included); 2) some of the categories were too broad (e.g., "All supports and services for the individual were discussed by the team member providing services: active treatment, behavioral, medical"), which made it difficult to determine what a "yes/no" response meant; 3) it was not clear whether the measures consistently measured the QIDP's facilitation skills (e.g., "Addressed preferences, strengths, and needs" left it unclear whether the QIDP's skills at soliciting this information from the team was being assessed or just that the QIDP listed these during the meeting); and 4) the standards or criteria used for each of the categories were not listed, which would be important to ensure the results could be replicated consistently and used to identify specific skills or competencies that needed improvement. ▪ Based on observations of 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 QIDPs 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 QIDPs 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. o Making sure decisions the teams make are data-based to the extent possible. A number of gaps continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. It was positive, though, that the teams were discussing objective clinical data in a number of areas. o Developing measurable objectives. 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., for Individual #240, will be "educated	

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		of all positive things and negative things about smoking, including the short term and long term health risks"), rather than as a change in the individual's life (e.g., Individual will decrease cigarette smoking from one pack a day to two cigarettes a day). o To improve integration of supports, QIDPs 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. Based on the Monitoring Team's review, progress had been made. However, based on observations as well as review of ISPs, some improvements were seen, 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, the Facility did not have a valid process for determining QIDPs' competence 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 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.	In Section II.A, DADS Policy #004.2 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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 DADS November 2013 ISP policy had an attachment (Exhibit A) that included some guidance on when particular team members' attendance should be required. The document was entitled "Annual ISP Meeting IDT Attendance Indicators." The QIDP Department leadership pulled a sample of ISP Preparation documentation to review the quality of the teams' identification of team members. ▪ After the preparation meetings, QIDPs were responsible for sending an attendance memo that identified the required attendance as well as related assignments. ▪ 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 noted in the Monitoring Team's last report, as part of the ISP Workgroup	Noncompliance

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		initiatives, training had been provided to QIDPs 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 noted in the last report, 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. ▪ On 12/4/13, based on ISP meeting attendance data, the QA/QI Council approved a Corrective Action Plan to address concerns noted with attendance of individuals, their guardians, and direct support professionals. This included a number of steps, including, but not limited to: the QIDP confirming with the Residential Coordinator five days prior to the ISP meeting that the individual would attend, and ensuring no other conflicts had arisen; at the ISP Preparation meeting, identifying the specific direct support professional that would attend the ISP meeting; taking steps to ensure accommodations were made to facilitate guardian attendance at meetings; requiring approval from the QIDP Coordinator to proceed with an ISP meeting without a guardian; and beginning on 10/1/13, QIDPs completing a tracking log, including the reason if any of these team members were not present. Based on data from July 2013 through December 2013, attendance of individuals had shown a fairly steady increase (i.e., 80% in July to 91% in December), guardian attendance continued to fluctuate from month to month (i.e., 70% in July, a high of 88% in October, and a decrease to 60% in December), and direct support professional attendance had shown a fairly steady increase (i.e., 75% in July to 92% in December). Based on a review of the aggregate information collected through the tracking sheet, the detail the QIDPs were providing should be helpful. Analysis of this information will be an important next step as the Facility moves forward with its efforts to improve attendance across these categories of team membership. The Facility provided data on attendance for the one-year period from November 2012 through October 2013. According to the Facility's data, the average percentage of attendance by required team members was 91% in November 2012 and 82% in October 2013 (with a range of 80% to 91%). The Facility provided additional data for the months of November and December 2013. In November, the average percentage of attendance was 87%, with a range per team member of 0% (i.e., Dental) to 100%. In December, the average percentage of attendance was 83%, with a range per team member of 0% (i.e.,	

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		Dental and Pharmacy) to 100%. In the Presentation Book, the Facility had completed some analysis of the data, and had identified the Dental and Pharmacy Departments' low attendance. The Presentation Book stated: "The recent addition of a new Dental Assistant is going to allow greater participation in the Annual ISP Meetings by the dental department." As noted in previous reports, 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. This remained a concern for this review. Until this is corrected, it will be difficult for the Facility to interpret its data. Based on the sample of 10 ISPs the Monitoring Team reviewed: ▪ For the 10 individuals in the sample, at the ISP Preparation Meeting, 10 teams (100%) defined the members of the team that should attend the annual meeting. ▪ Nine of 10 individuals had strengths, preferences, or needs that potentially required additional team member participation. The one exception was Individual #7 for whom the team identified all necessary team members. For none of these nine individuals (0%), the teams had adequately justified why such team members' participation was not necessary. Of note, in identifying team members that needed to be present, the teams often used phrases such as "assessment will suffice." These types of statements did not provide adequate justification for the teams' decisions. 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. In addition, teams often did not specify which therapists' attendance was required, but instead stated: "HT Rep." The teams should determine which therapists need to attend based on the individuals' needs, as well as strengths and preferences. ▪ For two of 10 (20%) (i.e., Individual #214, and Individual #20), it appeared that a duly constituted team participated in the annual meetings. The Facility had made progress in that increased participation in ISP meetings was seen for a number of disciplines. Teams were consistently using the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and the Facility 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	

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		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: ▪ In reviewing a sample of ISPs, at the ISP Preparation Meetings, individuals' teams were identifying assessments that team members were required to prepare for the ISP meeting. As noted below, problems were identified with this process, including a lack of justification for not requiring assessments related to individuals' specific needs. ▪ As noted in the Monitoring Team's last report, as part of the ISP Workgroup, Department Heads and their staff were required to sign and ISP Expectations acknowledgement form. Part of this form addressed assessments, 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 assessments to the shared drive 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. ▪ As noted in the Monitoring Team's last report, to address the issue of timeliness, the ISP Workgroup put a number of systems in place: o Departments were required to maintain tracking systems. o The ISP Technician also continued to maintain the ISP Assessment Tracking Report, and monthly reports continued to be shared with Department Heads. This allowed analysis of where the problems might lie when assessments were not submitted timely for the ISP process. o The data continued to 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 As noted in the Monitoring Team's last report, the ISP Workgroup had developed a "back page" summary for assessments. 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. Since the Monitoring Team's last review, State Office had issued assessment	Noncompliance

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		formats to all disciplines, and these formats required the inclusion of the information that LBSSLC had included on its "back pages." According to the QIDP Coordinator, after the ISP Preparation meetings, the QIDPs at LBSSLC continued to send team members the "back pages," which included information that could be transferred to the new assessment formats. This potentially made it easier for assessors to summarize this information in their assessments. o Based on review of the ISP Workgroup Action Plan and interview with the Director of the QA Department as well as the QIDP Coordinator, the ISP Workgroup was in the process of developing a quality check system for the ISP assessments. More specifically, the ISP Workgroup developed an outline for an Assessment Quality Checklist. At the time of the onsite review, discipline leads had been assigned the task of individualizing the checklist for their assessments. It was anticipated that once the audit forms were finalized, discipline leads would review the assessments for a sample of four records each month. The Facility provided data on timeliness of assessments for the one-year period from November 2012 through October 2013. The data was presented by discipline/type of assessment. For November 2012, the average was 74%, with the range of timeliness from 12% to 100%. For October 2013, the average was 83%, with the range of timeliness from 18% to 100%. The Facility also provided updated data for November and December 2013. For December 2013, the average was 86%, with the range of timeliness from 17% to 100%. Based on review of a sample of 10 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. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address clinical and therapy supports. As noted above, the Facility had a plan to develop audit tools, and implement them for a sample of assessments each month. This should assist in providing feedback to assessors, as well as in identifying any systemic issues related to the quality of assessments. ▪ As discussed in previous reports, although since the last review, some limited 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. Interestingly, some of the OT/PT and/or Speech-Language assessments (e.g., Individual #139 and Individual #21) included a fairly extensive, although not exhaustive, list of supports the individual would require in the community.	

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		Presumably, the individual required these same or similar supports at LBSSLC, but the recommendations for what needed to be provided while the individual remained at the Facility did not include supports similar to what was identified as necessary should the individual transition to the community. ▪ 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, at the time of the onsite review, this process was in transition given State Office had sent new formats for assessments. The QIDP Coordinator explained that QIDPs continued to send the "back pages," so that assessors could cut and paste information into the new assessment formats. Based on review of the sample of ISPs, assessors had used a combination of the back pages and/or the new State Office assessment formats. Regardless, assessments frequently did not clearly identify a full set of recommendations. ▪ Another issue identified was related to the listing of the individuals' strengths and needs in assessments. Although they were now more often listed on the "back pages" or in the new assessment formats from State Office, there was little evidence that assessors had incorporated them in meaningful ways in the resulting recommendations. Based on the sample of 10 ISPs: ▪ For these 10 individuals, at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for nine (90%). No assessment listing was found in the ISP Preparation Meeting documentation for Individual #97. ▪ In reviewing the ISPs for 10 individuals, the teams for four individuals (40%) 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. Those teams that had identified the necessary assessments included the teams for Individual #3, Individual #240, Individual #109, and Individual #20. ▪ For one of the 10 (10%) (i.e., Individual #97), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. Of note, it was often difficult to determine the timeliness of assessments, because of the multiple dates included on assessment. More specifically, the dates of assessments and dates of signatures of assessments often were different. In addition, filing dates stamped at the bottom were often weeks or even months after the assessment or signature dates. Although it was understood that electronic copies were supposed to be made available in the shared drive 10 days prior to the ISP meeting, this latter issue called into	

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		question why assessors had not submitted paper copies of assessments for filing sooner, or why they had not been timely filed. 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. For nine of the 10 individuals included in this sample, the ISPs listed the individual's injuries and allegations over the previous year. For one (i.e., Individual #3), it could not be determined, because pages were missing from the ISP document the Facility submitted. Some individuals appeared to have had few injuries or allegations. Only Individual #97's ISP, though, documented some team discussion about causes and potential ways to reduce the minor injuries the individual had sustained. As a result, it was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISPs. The following provide some examples of where further discussion was needed: ▪ Although the team explained to the guardian that an individual that had broken Individual #214's wrist six months earlier was still living with him, the only action was that "consideration" was being given to moving the other individual. There was no discussion about the possibility of Individual #214 moving, other protections, etc. ▪ For Individual #21, no summary was provided of the specific locations or causes of injuries, and so it could not be determined if additional action could have been taken to prevent future injuries. ▪ For Individual #315, the team discussed in some detail his various injuries. However, full analysis was not completed. For example, were the same peers involved in peer-to-peer injuries? Could falls have been prevented? In addition, action plans that appeared to have some impact last year (e.g., applying lotion to dry skin) were described as "completed" and not continued without explanation. ▪ For Individual #109, the team listed each injury, but did not document an analysis to determine if repeated scratches that were self-inflicted showed a need to take additional action (e.g., cut/file nails more regularly). 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	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	Noncompliance

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	supports to be provided to the individual.	incorporation of assessments into ISPs: ▪ Based on the Monitoring Team's review of 10 ISPs, none of the 10 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 As noted with regard to Section F.1.c, many assessments included minimal recommendations. As a result, it was not clear what protections, supports, and services, the assessors had determined the individual required. As noted above, some assessments included lists of supports individuals would require if they moved to the community, but corresponding recommendations for the supports the Facility would provide over the coming year did not include equivalent services and supports. o The assessment results were not translated into recommended action plans, including measurable, functional objectives. 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. Based on the ISPs and related assessments submitted, 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. The Facility remained in noncompliance with the provision.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United	Based on information the Facility provided, the following activities had occurred to provide additional education to QIDPs regarding community living options and/or to facilitate teams' implementation of the requirements of this subsection: ▪ Transition Specialists were attending ISP Preparation meetings for individuals	Noncompliance

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	States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	for whom a transition might be recommended. They had developed a flier that provided information about their role. ▪ The Admissions and Placement Coordinator attended monthly QIDP Department meetings to update or train QIDPs on Living Options procedures. ▪ On 10/8/13, QIDPs participated in training on new monitoring procedures for Sections F and T, and living options documentation in the ISP. ▪ On 10/18/13, QIDPs participated in training on developing individualized action plans related to living options. Examples were provided, including an example of individualized community provider tour questions. 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. Ten 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 10 ISPs reviewed, for two (20%), all of the assessments included the applicable statement/recommendation. Those individuals for whom all assessments included recommendations were Individual #214, and Individual #20. o Of the 10 ISPs reviewed, two of the individuals had been referred for transition to the community (i.e., Individual #97, and Individual #240). For Individual #3, it appeared that pages were missing from the copy of the ISP the Facility provided to the Monitoring Team, so Individual #3 was removed from the sample for these indicators. Eight of the remaining nine individuals' ISPs (89%) included a clear recommendation from the professionals on the team to the individual and LAR. As discussed below, Individual #240's team did not make a clear recommendation to the individual. For two of the nine individuals (22%), adequate justification was provided for the team's recommendation (i.e., for Individual #214, and Individual #9). The following provide examples of the problems identified: ▪ For Individual #240, the ISP indicated that many Facility discipline members recommended community transition, but psychiatry and psychology did not due to concerns that Individual #240's behaviors could result in criminal charges in the community. The team stated that there had been a similar	

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		lack of consensus last year, but through the review team process, the Facility Director had determined that a referral would be made. The team went on to continue the referral, despite the continuing lack of consensus. It was not clear why this lack of consensus was not again the subject of a review team process. ▪ For Individual #139, the team did not reconcile discrepancies between various team members' independent recommendations. For example, the dentist said he could be supported in the community, but other team members said he could not, and this difference of opinion was not reconciled. The team concluded that due to guardian choice and medical issues, Individual #139 should not be referred. Although the guardian's opposition was documented, the team did not explain in any detail its concerns about medical supports, or the specific supports it believed were not available. ▪ For Individual #97, the PCP and nurse had not recommended referral to the community. Although the recommendation of team members provided an explanation of how the PCP had changed her mind, no reconciliation of the nurse's recommendation was described. ▪ For Individual #21, based on the summary and review of the assessment, disciplines made varying recommendations, including some that indicated the individual could transition to the community, and others that did not. The team, absent the individual, recommended against transition, but no explanation was provided to reconcile the differences of opinions, or explain how a number of team members changed their minds. ▪ For Individual #315, the psychiatry assessment indicated: "Community placement is not recommended due to the history of episodic aggression." This recommendation was not reflected in the ISP, and it is unclear how this recommendation was reconciled with other team members' recommendations. ▪ For Individual #109, the team concluded that he could not be supported in the community despite the fact that five of 11 team members had indicated he could be served in the community. No documentation was found of how these five team members changed their minds, or how the team reached this consensus. ▪ For Individual #20, the team concluded that due to a change in	

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		her behavior, that included increased peer-to-peer aggression, a move was not recommended. It was explained that this change occurred after the disciplines made their recommendations in the assessments. What was not clear from the discussion was whether the team had considered that a smaller living environment might benefit Individual #20, whose preferences included: "quiet environment," and "being left alone." ▪ 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 being referred 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 teams had not identified 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 many team members were including statements in their assessments with regard to individuals' appropriateness for community transition, all team members were not. Teams generally were making recommendations to the individuals and/or LARs, but 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,	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	Noncompliance

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	each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS Policy #004.2 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 10 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. However, some lists were still quite limited. ▪ Review of the PSIs showed that they were not consistently fully completed and the quality of the PSI also needed improvement (as discussed in further detail with regard to Section S.2). Similarly, based on the reviews of the PSIs for the 10 individuals in this sample, information that was included in the PSIs was not necessarily well summarized, despite now a summary section at the end of each major section, and so key pieces of information that would be important to the teams were not consistently included in the ISP Preparation Meeting documentation or the ISPs. ▪ 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. Many examples were provided in the previous report of missed opportunities for incorporating individuals' preferences into action plans in a manner that would build upon them, and potentially result in growth for the individual. ▪ 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. Again, examples were provided in the previous report of missed opportunities to build upon individuals' strengths.	

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		<u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of the sample of 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 10 ISPs reviewed (10%), barriers were identified, but in none (0%) did the team sufficiently address them. For Individual #139, the individual's diagnosis of an infectious illness was identified as a barrier to completing his programs, but the team developed no plan for providing alternatives or modifying current programming. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ One of the 10 ISPs reviewed (10%) (i.e., Individual #214 to make a purchase in a restaurant or store in the community) included specific skill acquisition plans for implementation in the community. ▪ Seven of 10 individuals' ISPs (70%) included at least one measurable objective to enhance individuals' general participation and integration into their communities. Those that did not were for Individual #139 and Individual #21 (i.e., who were on isolation due to an infection, but the ISPs were developed for the year, and should have included objectives for implementation once the infection cleared), and Individual #214 (i.e., the action step was not measurable). However, some of these were quite limited (e.g., for Individual #20, the objective was for the individual to be involved in community trips two times per month, and no detail was provided regarding what such activities might entail). ▪ Of continuing concern, 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. The only individual in the sample for whom some such opportunities were envisioned through the objectives/action plans was Individual #240. For this individual, action steps were included to refer him for potential supported employment/employment in the community, and participation in a volunteer group that interacted with non-disabled peers on	

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		occasion. Although LBSSLC had made some limited progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals and some expansion of these was noted, 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. ISPs reviewed generally did not include action plans that addressed community skill acquisition. Although most plans included some community activities, they generally did not encourage participation in the community with nondisabled peers. Of concern, data the Facility provided in the Presentation Book did not identify problems in these areas, except in relation to ISPs encouraging community participation.	
	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. LBSSLC recognized the need to improve action plans in ISPs. The ISP Workgroup had this as one of its focus areas. Based on interview and documentation in the Presentation Book for Section F, the QIDP Educators had provided training to QIDPs on writing action plans. This training included some practical exercises aimed at ensuring that all necessary components of action plans were included. In addition, the QIDP Coordinator and QIDP Educators were monitoring completed action plans, and reviewing draft ISPs. Based on the results of these reviews, they were providing feedback to QIDPs. Given that the IHCP is a key part of the ISP, and the RN Case Managers had primary responsibility for drafting these, it will be important for them to complete similar training. The following summarizes the findings related to action plans: ▪ None of the 10 plans reviewed (0%) included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. ▪ None of the plans (0%) included a full set of measurable objectives. ▪ 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.	Noncompliance

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		▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, action plans related to obstacles to transition were not sufficiently individualized, and often did not address the obstacles identified. In the Monitoring Team's previous report, numerous examples were provided of both positive and negative aspects of the action plans in the ISPs reviewed. The comments for this most recent set of ISPs remain the same. Facility staff are encouraged to reread this subsection of the last report. The following briefly summarizes concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Since the last review of LBSSLC, the scope of these goals and objectives had continued to increase. This was a positive development. Action plans in ISPs continued to include skill acquisition plans, and teams were developing the Integrated Health Care Plans. However, IHCPs continued to require significant improvements, and limited discussion of them occurred during ISP meetings, particularly in relation to the measurable goals that teams needed to include in them. Generally, specific PBSP objectives were not included, and often only a reference was made to implementation of the PBSP. Similarly, psychiatric and medical treatment plans generally were not incorporated into the ISP through the inclusion of measurable goals or objectives in IHCPs. ▪ Clearly, efforts were being made to make ISP action plans and IHCPs more measurable, but substantially more work was needed in this regard. All plans in the sample included objectives that could not be measured (e.g., for Individual #139, "DSP will visit and interact with [Individual #139] at least 1 time per shift on 6/2 and 2/10 shifts," or "[Individual #139] will attend programming on the home;" or for Individual #315, "To prevent [Individual #315] from choking/Aspiration/respiratory distress as evidenced by providing him with the identified supports below," or "To prevent complications related to Constipation as evidenced by providing the identified action steps listed below;" or for Individual #214, ., "encourage to drink fluids," "encourage to walk"). ▪ The plans had begun to include some clinical indicators in the form of measurable goals. Sometimes, these "goals" were measurable, because the action plan included processes for collecting data, completing laboratory work, etc., and someone was assigned to monitor the information on a regular and specifically stated basis. For example, in some very limited cases, IHCPs included goals/objectives to allow the team to determine whether the individual	

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		was improving. The following examples were representative of other ISPs reviewed, and are used only as examples of the larger issues. o For Individual #139, a positive example was found in one action plan: One of the goals in the IHCP was: "will have no incidence of choking, aspiration or respiratory compromise AEB [as evidenced by]: lungs clear to auscultation bilaterally, no cyanosis, respiration 12-20, no temperature greater than 101.0, and Oxygen Sats [saturation rates] greater than 92%." All of these clinical indicators were then measured through objectives with defined timeframes, persons responsible, location of documentation, and person responsible for review. What was not consistently clear was how frequently the data would be reviewed. o For Individual #240, the following illustrated missing measurable objectives. His IHCP included references to the PBSP, MOSES, DISCUS, and quarterly face-to-face psychiatric assessment, which was positive. However, measurable goals/objectives were not included (e.g., instead: "Maintain a controlled and safe environment for self and others." "Will remain free from side effects of medications," "DSP to follow PBSP," or "Moses Q [every] 6 months." With no baseline and no measurable goals, progress or lack thereof could not be tracked. ▪ Of ongoing concern, the objectives or actions steps for vocational and day program activities were extremely limited, and usually related to attending during certain hours (many of which represented part-time schedules without adequate justification), or "continuing" to work on specific projects or activities. Limited, if any, goals or objectives were targeted towards expanding individuals' day and vocational options or helping them to learn new skills. ▪ As is discussed in further detail with regard to Section I, the action plans teams had developed for individuals' at-risk issues did not adequately address their needs, and most did not include measurable objectives necessary to determine: a) if the supports outlined were provided as required; or b) whether or not the supports and strategies were having the desired outcome (i.e., were they effective in improving the individual's health, or maintaining his/her current status). ▪ Objectives often were not individualized. For example, in some plans the nursing protocols had simply been copied, and did not appear to have been individualized to address specific needs. Similarly, many action plans related to overcoming obstacles to referral to the community, or to expand individuals' relationships were identical from ISP to ISP, showing no individualization. ▪ In most plans, objectives were not seen in relation to staff training requirements. Some progress had been made in the expansion of the scope of measurable objectives,	

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		and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. These remained areas in which significant work was needed. Of concern, data the Facility provided in the Presentation Book did not identify problems in these areas. 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: ▪ Integration of various plans (e.g., medical treatment plans, PBSPs, psychiatric treatment plans, PNMPs, desensitization plans, respiratory therapy plans, walking plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. Although the PNMPs often and PBSPs occasionally were identified in action plans as needing implementation, reference usually was not made to the specific plan approved (i.e., by date), and limited, if any, goals/objectives/action steps were included in the ISPs in relation to the plans. ▪ 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. Most plans did not define roles for medical, psychiatric, Habilitation Therapy, or Behavioral Health Services staff. ▪ The IHCPs did not consistently include the supports that the team identified in the IRRF. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ Most plans included reference to skill acquisition plans, as well as service objectives. An improvement was that the measurable objectives for the SAPs generally were set forth in the ISPs. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. Previous reports have provided details about what was missing. ▪ Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. None of the 10 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Some limited improvements were seen. However, as noted above, teams will need additional coaching	Noncompliance

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		and mentoring to 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 10 ISPs (0%), action plans included adequate timeframes for completion. ▪ For three of the 10 ISPs (30%) (i.e., Individual #139, Individual #21, and Individual #240), the roles of the persons identified as responsible were clearly defined. This most recent review showed some improvement, and as noted above, it was clear that efforts were being made to improve the measurability of action plans. However, the following summarizes some of the problems noted: ▪ Although some improvement was seen, the use of terms such as "as scheduled" or "as requested" sometimes continued to be used as the timeframe for completion or frequency. These generally were not sufficient to make the objectives measurable and/or clearly define staff's responsibilities. Timeframes that clearly should be known based on the teams' discussion of the IRRFs were not included, such as "will attend dental as requested." ▪ Timeframes often were missing for the frequency of review. For example, in many ISPs, a number of action steps required direct support professionals and nursing staff to "monitor for signs and symptoms of..." However, a frequency was not provided and the location of documentation was listed as something like: "acute issues will be addressed and documentation in IPN will be completed." As a result, the frequency of monitoring was unclear, and it was not clear how the team would know that proactive monitoring was occurring. ▪ In IHCPs, in some very limited cases, overall goals now included measurable indicators to allow measurement of an individual's status. However, the methods for measuring or the staff responsible for measuring them generally were not provided. ▪ Often two positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. ▪ An issue related to the identification of staff responsible noted was the use of term "IDT" as opposed to a specific member(s) of the IDT (e.g., the Nurse Case Manager, or the PT, or OT, etc.). Particularly, when it comes to monthly monitoring of programs/supports, it will be important for one person to be identified. In addition, by using this broad description everyone in a department was responsible, but no specific staff member was responsible, reducing the level of accountability. ▪ Although persons responsible generally were identified, many steps were missing, so it was unclear who was responsible for specifics such as wheelchair/adaptive equipment maintenance, role of Respiratory Therapist, etc.	Noncompliance

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		▪ 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 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. With regard to methodologies in action plans: ▪ In none of the 10 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, and in many cases, no methodology was provided at all [e.g., for Individual #97, methods were missing for activities such as maintaining adequate fluid intake, what his participation in day program would entail, etc.; for Individual #21, more than just nursing and direct support involvement was necessary to meet Individual #21's needs, but these were the only methodologies included in the IHCP; for Individual #214, often the methods were not included, for example, to encourage fluid, or ensure he brushed his teeth, and for a number of goals, the full set of methods was not included; and for Individual #240, he was to be "educated of all positive things and negative things about smoking, including the short term and long term health risks" on a daily basis, but no methodology was described]. ▪ Methodologies were often reactive as opposed to proactive. For example, nursing protocols were to be implemented: "when signs and symptoms of respiratory distress, gastrointestinal issues, etc. are reported," as opposed to using nursing protocols proactively. In addition, most often, the etiology of the healthcare concern was missing, so it was unclear what steps reasonably could have assisted with these risk areas. ▪ 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.	

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		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. Of concern, data the Facility provided in the Presentation Book did not identify problems in these areas.	
	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	None of the 10 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to the lack of inclusion in ISPs of plans to address conditions that placed individuals at-risk, psychiatric treatment plans, nursing care plans, OT/PT treatment plans, speech therapy plans, and PBSPs. All plans included some practical and functional interventions. In fact, most skill acquisition plans identified functional skills to be taught. However, many of the same skill acquisition programs were found in multiple ISPs, and as discussed above, information was not found in the ISPs or ISP Preparation documentation to show why one skill over another was selected for each individual. As a result, it was difficult to determine if these training programs were individualized to improve functional skills that were meaningful for the individual. 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. 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 consistently work to achieve more functional outcomes for individuals (i.e., in an integrated fashion with assistance from behavioral health services staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals'	Noncompliance

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		limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. The following provide positive and negative examples of teams' efforts to expand individuals functional skills: ▪ The following was an example of where the team missed opportunities to increase the individual's functional skills. For Individual #240, the team identified dressing like a security guard as a problem, and as a potential safety issue should he move to the community. Behavioral Health Services recommended addressing it through "Good Life Therapy," which was described as watching movies and then discussing plans for a good life. It should have been addressed through formal planning, of which this might have been one step. However, the ISP did not show an integrated approach, and/or use of his current strengths and preferences to resolve issues that impeded greater independence. Similarly, due to issues with Individual #240 not bathing regularly or cleaning his room, the FSA recommended SAPs for bathing and cleaning/organizing. The ISP stated: "The Psychologist stated that [Individual #240] has the ability to bathe and clean but he chooses not to do so; therefore, training is not recommended in these areas at this time. The Psychologist stated that SAP's [sic] are developed for the purpose of training." Based on the documentation in the ISP, the Behavioral Health Services Provider offered no alternatives for improving Individual #240's adherence to these basic independent living skills, and the ISP included no plan to overcome his refusals. ▪ During the onsite review, the Monitoring Team observed a team meeting for Individual #264, during which some team members advocated strongly to develop plans that would improve the individual's functional skills. This required the team to expand the expectations set for both Individual #264 as well as the team. The discussions resulted in the development of some plans and SAPs that should facilitate greater independence for Individual #264 (e.g., his community outing goal that was designed to increase his tolerance for riding in the van, for which, after some discussion, the team appropriately decided upon a frequent training schedule). However, some team members continued to have low expectations and were resistant to other team members' suggestions that more assertive goals be set. For example, based on a vocational assessment, which appeared limited to what was currently available on campus, the recommendation was for him to continue in his current program, and increase the number of minutes he participates. Although some team members believed this was too low an expectation, the day program representative did not agree, and stated: "Remaining on task is a pre-requisite to vocational activities." Given that one of Individual #264's strengths was listed as: "is capable of learning and maintaining attention for long periods of time when it is something that	

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		interests him," it appeared the team had not yet found a vocational task that interested him, and further assessment was required. The Facility remained out of compliance with this provision.	
	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 10 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. 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." The following provide positive and negative examples of teams' efforts to define the data to be collected, frequency of data collection, and persons responsible for both data collection and review: ▪ The ISP for Individual #139 included some good examples in the IHCP of data that needed to be collected and reviewed [e.g., vital signs, oxygen saturation rates, Bowel Movement (BM) log, etc.]. The persons responsible for data review were identified, but the frequency of data review was only identified sometimes. For example, one of the goals in the IHCP was: "will have no incidence of choking, aspiration or respiratory compromise AEB [as evidenced by]: lungs clear to auscultation bilaterally, no cyanosis, respiration 12-20, no temperature greater than 101.0, and Oxygen Sats [saturations] greater than 92%." All of these clinical indicators were then measured through objectives with defined timeframes, persons responsible, location of documentation, and person responsible for review. What was not consistently clear was how frequently the data would be reviewed. ▪ For Individual #214, no mechanisms were included to collect data to show whether for his IHCP goals he was doing better, worse, or remaining stable. For example, a goal was for him not to have any episodes of constipation, but no mechanism for knowing whether he had BMs were included (e.g., maintenance of bowel record). ▪ For Individual #240, the IHCP included references to the BSP, MOSES, DISCUS, and quarterly face-to-face psychiatric assessment, but measurable goals/objectives were not included (e.g., instead: "Maintain a controlled and safe environment for self and others. Will remain free from side effects of medications," "DSP to follow PBSP," or "Moses Q [every] 6 months"). As a result,	Noncompliance

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		the data to be collected was not defined. 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 nursing care plans, psychiatric treatment plans, PBSPs, PNMPs, 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, some improvement was seen with some teams in terms of defining the data to be collected, frequency of data collection and review, and persons responsible. However, much work was still needed in this regard. The Facility remained in noncompliance with this provision. Of concern, data the Facility provided in the Presentation Book did not identify problems in these areas.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the previous reports, and based on the current review of ISPs, this was an area that required improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.2 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. LBSSLC had taken some steps to provide information to direct support professionals in an easily understood manner. For example: ▪ Individual Activity Cards had been developed for each individual. These cards	Noncompliance

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		included some key information about the individual, including, for example, allergies, and preferences for activities. The Active Treatment Department was responsible for updating these cared, and providing in-service training to direct support professionals on them. ▪ Once ISPs were completed, QIDPs printed the action plans on yellow paper, and placed them in the Individual Notebooks. This provided a quick reference for individuals' goals and objectives. ▪ The QIDP Department created the Direct Support Professionals ISP Competency Monitoring Tool, revised 12/22/13. On 10/21/13, QIDPs were trained on the use of the tools. At the time of the review, QIDPs had begun to implement the tool to measure direct support professionals' competency with regard to the IAC cards, and key components of the ISPs, such as the goals, PBSP target behaviors, rights restrictions, and SAPs. For scores below 80%, a plan was developed and implemented. Based on examples provided, this usually involved retraining staff. This was a positive practice that should assist the Facility in addressing specific staff training issues. In addition, if data is reviewed in the aggregate, it might be useful in determining if there are issues related to the comprehensibility of plans. In the last report, the Monitoring Team indicated that LBSSLC had begun to run a sample of ISPs through a program to determine readability level. The Facility did not provide similar information during this most recent review. As discussed in previous reports, an 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, the ongoing issue 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). 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.	

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F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004.2 at III.A addressed ISP monthly reviews. 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. Monthly reviews were being completed more consistently than in past reviews, but problems continued to be noted with regard to timeliness, as well as the content of the monthly reviews. More specifically: ▪ Based on the sample of 10 records, all individuals had three monthly reviews, but none (0%) had timely monthly reviews each month for the previous three months. ▪ For none of the monthly reviews completed (0%), the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. The reports only included the QIDPs' review of skill acquisition programs, other service objectives at the end of the ISP document (i.e., not in IHCPs or other plans referenced in the ISP), and some brief updates on specific topics (e.g., incidents and allegations, hospitalizations, etc.). No summary was provided with regard to various team members' review of "each program or support included in the ISP." Very brief and not always useful summaries were provided with regard to the action plans that were discussed. ▪ For eight of the 10 individuals, a lack of expected progress was noted requiring action. For none of the eight (0%) did it appear action was taken (i.e., Individual #139, Individual #21, Individual #315, Individual #214, Individual #240, Individual #109), and/or action was taken for all identified issues (i.e., for Individual #20, and Individual #7, some action was identified as necessary, but not all issues were addressed). As noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if additional problems existed that should have been addressed. An ongoing concern about the monthly reviews was the lack of data to substantiate individuals' progress or lack thereof. The narrative summaries should summarize the data and provide a description/analysis of the data, so it is clear to the reader what the data means. Based on interview and information in the Presentation Book, in October 2013, training was provided to QIDPs on the monthly review process. The QIDP Educators were reviewing monthly reports, and providing constructive feedback to the QIDPs and teams, which was a positive practice. A tracking system also was in place to ensure that QIDPs	Noncompliance

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		completed monthly reviews. Moreover, examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Examples of this are provided with regard to nursing care, as well as physical and nutritional management supports. Although some progress had been made in the completion of monthly reviews, the Facility did not yet have an adequate monthly review process in place. The Facility remained out of compliance with this provision.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	In previous reports, the Monitoring Team has provided details regarding the training provided to QIDPs 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: ▪ 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, QIDPs began assisting the QIDP Educators with New Hire Supporting Visions Training. This practice continued at the time of the most recent review; ▪ New QIDPs continued to undergo Q Construction training, and in October 2013, the Facility had required all QIDPs to participate in the Q Construction training as a refresher. 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 above, QIDP Educators had developed and implemented training for QIDPs on various topics, such as the development of action plans, and completion of monthly reviews. ▪ As noted in previous reports, of significant note was the development and implementation of an On-the-Job training process for new QIDPs. 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: ▪ As discussed with regard to Section F.1.a, QIDPs should be required to	Noncompliance

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		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. Since the last review, the QIDP Coordinator had developed a Facilitation Skills Performance Tool, undated. The Facility submitted a list showing that nine out of 15 QIDPs had been deemed competent using this tool, with one QIDP identified as "needs work," four that had not been assessed, and one vacancy. Unfortunately, the tool did not sufficiently measure QIDP competence with meeting facilitation. A number of problems were noted with the tool, including but not limited to: 1) numerous facilitation skills were missing from the list, including a number of skills that the Facility had identified in the training provided to QIDPs in November 2013 (e.g., just as one of many examples, the QIDP's ability to facilitate discussion amongst team members with the result of the development of integrated services and supports was not included); 2) some of the categories were too broad (e.g., "All supports and services for the individual were discussed by the team member providing services: active treatment, behavioral, medical"), which made it difficult to determine what a "yes/no" response meant; 3) it was not clear whether the measures consistently measured the QIDP's facilitation skills (e.g., "Addressed preferences, strengths, and needs" left it unclear whether the QIDP's skills at soliciting this information from the team was being assessed or just that the QIDP listed these during the meeting); and 4) the standards or criteria used for each of the categories were not listed, which would be important to ensure the results could be replicated consistently and used to identify specific skills or competencies that needed improvement. ▪ 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 QIDPs 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,	

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		while reconciling these with the individuals' medical and safety needs. Although since the last review, some training had been provided on action plans, the Facility staff indicated writing action plans continued to be a struggle. ▪ This section of the Settlement Agreement also requires: "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." As discussed above, this was an area in which the Facility had made progress, but CTD was working on a process of tracking the training. Focus should be placed on ensuring that the training for staff includes all relevant portions of the ISP, and that staff in both residential services as well as day and vocational services complete the necessary training. 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/revised and implemented for facilitation of ISP meetings and the development of the ISP documents. The Facility also 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 5/15/13 and 11/15/13, three individuals had been admitted to the Facility. All three individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 218 ISP meetings were held between 11/1/12 and 10/30/13. Six 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 required 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 ISP Changes/Extension Memo Tracking. For 2013, it showed five extensions had been requested. According to the reasons listed, 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 an example of a memo showing the Facility Director's approval of such a request. As indicated in the Monitoring Team's last report, a number of steps had been taken to facilitate the completion of the ISP documents within 30 days. This included QIDPs developing draft ISPs before the meetings. In addition, the Facility had assigned QIDP typists for each ISP meeting. The QIDP typist attended the ISP meeting, and took notes	Noncompliance

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		and/or made changes to the draft ISP. This assisted the QIDP running the meeting, and resulted in a more complete draft of the ISP at the end of the meeting. After the ISP meeting, the QIDP took a pre-assigned "ghost" day and spent time finalizing the ISP, while another QIDP provided "ghost day coverage" by addressing any issues that came up on the QIDP's caseload. In addition, the Facility had developed timeframes for the QIDPs' completion of draft documents (i.e., ISP Preparation meeting documentation, the ISP draft for use at ISP meeting, and ISP document after the meeting) and submission to the QIDP Coordinator and/or QIDP Educators for review and comment. The reviewers then had timeframes to return the documents to the QIDPs with any comments. Finally, the QIDP had a specified number of days to finalize the final ISP document and send it for filing in the Active Record. These steps appeared to be having a very positive impact. Based on data the Facility provided, for the 218 ISP meetings held between 11/1/12 and 10/31/13, 162 (74%) were filed within 30 days after the ISP meeting. The Facility also provided data for the time period between 5/1/13 and 10/30/13. Based on data the Facility provided for this recent six-month period, 100 out of 101 ISPs (99%) were filed within 30 days after the ISP meeting. 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. As noted in the last report, the Facility had begun to take some steps to ensure staff were trained on individuals' ISPs. Specifically, once the ISP was completed, the ISP Technician sent the ISP to the Residential Coordinator. The Residential Coordinator made the ISP available to staff working with the individual. Staff were responsible to review the ISP and sign that they had completed a review. In addition, in-service training was required for a number of components of the ISP, and various staff were responsible to complete this training. For example, the RN Case Managers were responsible to train direct support professionals on all treatments included in the ISPs for which they were responsible, Active Treatment staff were responsible for providing training on the Individual Activity Card, Integrated Program Developers trained on the SAPs, Behavioral Health Services Providers trained on the PBSPs, and PNMP Coordinators trained any portions of the PNMPs that were not included in the standard training. At the time of the review, the Facility was using the ISP In-Service Tracking Tool to track the date an ISP was sent to the Residential Coordinator, the date in-service training was due, and the date the in-service roster was returned to the QIDP Department. Based on the data report the Facility submitted, for the 72 ISPs that occurred between 6/25/13	

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		and 10/30/13, training rosters were submitted within 14 days of the ISP Technician sending the ISP to the Residential Coordinator for 30 individuals (42%). Based on a review of the training documentation submitted for the sample of 10 individuals' ISPs, it was clear that the Facility had a system of sign-in sheets for documenting training on components of the ISP, such as the PNMP, SAPs and PBSP, as well staff's review of the ISP, and IAC. However, some training, such as on the IHCPs, had not been completed. In addition, it was difficult to tell from the documentation provided whether all relevant staff, including residential as well as day and vocational staff, had been trained on all necessary components. It was expected the Competency Training and Development Department would begin entering the ISP training data into a database soon. 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. It was anticipated that exception reports would be available soon. It will be important for such reports to identify the specific components of the ISP on which staff still require training. The Facility remained out of compliance with this provision. However, considerable progress was noted with regard to the QIDPs completing the ISP documents within 30 days of the ISP meetings. The Facility was working towards ensuring that staff were trained on ISPs to make sure the implementation of the ISPs began timely.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Positive aspects of the development and implementation of quality assurance processes to identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement included: ▪ DADS Policy #004.2 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ A Program Compliance Monitor from the QA Department, and the QIDP Coordinator were conducting the reviews. At the time of the review, the PCM selected a sample of four ISP meetings per month. The process included 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 related to Section F, 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 QIDP Coordinator met approximately monthly to review the results of monitoring activities, and maintained minutes. ▪ As noted in the last report, the Facility Director had set up the ISP Workgroup,	Noncompliance

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		which developed an action plan related to improving the ISP process. Areas of focus included: 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). At the time of the current review, these action plans remained 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. ▪ At the time of the most recent review, a scaled-down version of the group continued to meet to develop and oversee implementation of various action plans. Based on the Facility's own assessment, the Workgroup had prioritized some areas for attention. For example, a CAP had been developed and was being implemented to improve attendance of key people at ISP meetings (e.g., direct support professionals, individuals, and guardians). In addition, the Workgroup was focusing on the quality of assessments used in the ISP process, and plans were underway to develop audit tools for discipline leads to use to evaluate assessments. Areas in which improvements should continue to be made in order to achieve substantial compliance, included: ▪ Effective 10/1/13, the Facility had transitioned to the use of a new monitoring form. It was entitled: Annual ISP Meeting Preparation Checklist, dated 9/17/13. Although this tool 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 (e.g., Were plans developed to increase awareness of Living Options for individual and LAR/Family/Advocate?). For many other indicators, terms and/or standards were not defined. As a result, it was not clear that quality would be assessed consistently [e.g., Did the IHCP (for all medium and high ratings) reflect all appropriate services and supports to reduce the impact of risk?]. ▪ As noted with regard to the Self-Assessment, of significant concern, there was little correlation between the audit tool and the information included in the Facility's Self-Assessment. Except for a few indicators in the Self-Assessment,	

#	Provision	Assessment of Status	Compliance
		most of the information included in the Self-Assessment could not be linked directly to an indicator on the monitoring tool. This raised the question of how the information for the Self-Assessment was being collected, as well as how, if at all, the information collected through the audit tool was being used to meaningfully drive quality assurance efforts in relation to Section F. ▪ Based on the Facility's data, inter-rater reliability was over 90%. It was not clear this was accurate, though. For the new tool, the QIDP Coordinator indicated these scores had to be calculated by hand. The chart included in the Self-Assessment related to inter-rater reliability could not be interpreted. Inter-rater reliability needs to be calculated per question, and the information in the Self-Assessment was based on overall scores for each auditor. In addition, based on review of the Facility's findings in comparison with the Monitoring Team's findings, it appeared that even if the Facility's monitoring results were reliable, they were not valid for many indicators. This is particularly problematic, because if the Facility's monitoring results are not accurate, the Facility will not be able to appropriately identify and address areas of concern. ▪ As noted with regard to the Facility Self-Assessment, the Facility had completed some limited analysis of data, and had begun to connect findings with specific action plans or CAPs. ▪ The meeting minutes for meetings between the QA Department and QIDP Department showed limited identification of issues. For example, the August meeting minutes identified no areas of concern, and the September and October minutes only identified the need to file Skill Acquisition Program information timely. However, as noted above, the Facility Director had identified the need to focus on ISPs and their development, and the ISP Workgroup had put plans in place that were beginning to have an impact on a number of issues. It will be important to use monitoring results to determine whether or not these interventions are having the desired impact. 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. As some of the Facility's action plans, including those the ISP Workgroup developed are implemented, auditing and analysis of related data 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 provider morning meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 12/9/13 through 12/13/13; o For hospitalizations in prior six months, copies of follow-up Individual Support Plan Addendums (ISPAs) for the following individuals: Individual #299 ISPA 6/25/13, Individual #222 ISPA 6/10/13, Individual #222 ISPA 6/17/13, Individual #317 ISPA 6/12/13, Individual #281 ISPA 7/15/13, Individual #281 ISPA 7/24/13, Individual #284 ISPA 9/27/13, Individual #321 ISPA 7/16/13, Individual #321 ISPA 9/4/13, Individual #47 ISPA 9/30/13, Individual #22 ISPA 9/17/13, Individual #114 ISPA 9/3/13, Individual #283 ISPA 8/19/13, Individual #139 ISPA 8/7/13, Individual #139 ISPA 8/26/13, Individual #139 ISPA 7/9/13, Individual #139 ISPA 5/16/13, Individual #242 ISPA 6/11/13, Individual #33 ISPA 10/1/13, Individual #128 ISPA 5/21/13, Individual #283 ISPA 10/30/13, Individual #242 ISPA 10/29/13, Individual #171 ISPA 11/14/13, Individual #76 ISPA 11/13/13, Individual #323 ISPA 7/16/13, Individual #76 ISPA 9/23/13, Individual #258 ISPA 9/26/13, Individual #250 ISPA 9/17/13, Individual #136 ISPA 9/6/13, Individual #136 ISPA 6/7/13, Individual #233 ISPA 10/24/13, Individual #293 ISPA 9/23/13, Individual #43 ISPA 7/25/13, Individual #43 ISPA 7/30/13, Individual #43 ISPA 9/4/13, and Individual #181 ISPA 7/10/13; and o For one individual from each residence, copies of all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since the Monitoring Team's last onsite review and all Integrated Progress Notes (IPNs) commenting on consultant reports (i.e., medicine and surgery inclusive of subspecialties and the reason for agreeing not agreeing) and any ISPA related to the consultant report: Individual #196 Cardiology consult 7/16/13, Individual #196 Gynecology consult 8/14/13, Individual #19 Otorhinolaryngology (ENT) consult 8/13/13, Individual #171 Gastroenterology consult 11/1/13, Individual #171 Neurology consult 8/28/13, Individual #171 Neurology consult 8/7/13, Individual #171 Neurology consult 9/27/13, Individual #171 Neurology consult 6/26/13, Individual #171 Neurosurgery consult 8/1/13, Individual #265 Gastroenterology consult 9/18/13, Individual #265 Neurology consult 7/24/13, Individual #50 Oncology consult 11/19/13, Individual #50 Endocrinology consult 8/29/13, Individual #50 Vision consult 7/17/13, Individual #114 Neurology consult 9/4/13, Individual #114 Vision

	consult 9/6/13, Individual #114 Gastroenterology consult 8/14/13, Individual #114 Urology consult 6/17/13, Individual #114 Dermatology consult 6/25/13, Individual #114 Neurology consult 6/5/13, Individual #214 Orthopedics consult 7/16/13, Individual #214 Gastroenterology consult 5/7/13, Individual #214 Vision consult 10/25/13, Individual #125 Neurology consult 10/9/13, Individual #125 Endocrinology consult 7/31/13, Individual #125 Allergy consult 7/3/13, Individual #125 Allergy consult 8/2/13, Individual #125 Cardiology consult 8/19/13, Individual #284 Endocrinology consult 7/31/13, Individual #284 Neurology consult 9/4/13, Individual #284 Neurology consult 5/15/13, Individual #16 Neurology consult 5/8/13, Individual #16 Ophthalmology consult 8/29/13, Individual #16 Podiatry consult 8/21/13, Individual #16 Ophthalmology consult 9/4/13, Individual #16 Neurology consult 6/28/13, Individual #16 Vision consult 7/12/13, Individual #94 Urology consult 9/18/13, Individual #94 Neurology consult 10/9/13, Individual #94 Vision consult 8/2/13, Individual #94 Dermatology consult 11/5/13, Individual #94 Nephrology consult 10/21/13, Individual #190 Gastroenterology consult 11/6/13, Individual #190 Gastroenterology consult 10/4/13, Individual #190 General Surgery consult 9/17/13, Individual #190 Speech Language Pathologist (SLP) consult 7/23/13, Individual #190 Neurology consult 6/5/13, Individual #242 Endocrinology consult 8/29/13, Individual #242 Pulmonology consult 8/16/13, Individual #242 Urology consult 7/19/13, Individual #242 Urology consult 9/26/13, Individual #222 Orthopedic consult 7/12/13, Individual #222 Orthopedic consult 8/2/13, Individual #68 Allergy consult 9/18/13, Individual #68 Gastroenterology consult 7/23/13, Individual #280 Neurology consult 5/15/13, Individual #280 Allergy consult 8/13/13, Individual #280 Vision consult 9/6/13, and Individual #280 Neurology consult 10/23/13. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shultz, RN, BSN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ Monitoring/audit tools were not utilized for Section G, but were utilized in Section H and L. ▪ However, for Section G, the Facility used relevant data sources 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 used various databases and tracking systems (e.g., morning provider meeting attendance tracking, ISPA tracking for change of status, concerns needing closure at the morning provider meeting, open record review tracking, appointment tracking, etc.). ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the

	Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o For Section G, consistently measured the quality as well as presence of items, such as the post-hospital ISPAs. ▪ The Facility rated itself as being in compliance with subsections G1 and G2. This was only partially consistent with the Monitoring Team's findings. The Monitoring Team found the Facility to be in compliance with Section G.2, but not G.1. ▪ When the Facility data identified areas of need/improvement, training occurred, and action plans were developed and implemented, followed by further data collection.
	Summary of Monitor's Assessment: For Section G, the Facility continued to demonstrate implementation of a number of structures to assist in ensuring that individuals received needed services. The provider morning meeting tracked change of health status concerns as defined through hospitalizations and Emergency Room (ER) visits. Clinical care of those hospitalized was assessed by completion of open record reviews and discussion of findings, as well as post-hospital ISPA creation. The provider morning meeting provided the quality review of the content of the ISPA for individuals that experienced hospitalizations and ER visits, and ensured appropriate acute care and preventive steps were in place. Other closure concerns of various clinical areas that the group identified also were tracked to closure. Written documentation was required for closure to occur. Attendance also was tracked to ensure that all clinical disciplines were represented. A formal agenda was followed that allowed for weekly reports from other clinical disciplines, such as Laboratory, and Dietary Departments. The Facility had made progress with regard to the provision of integrated care, particularly through its provider morning meeting processes. Some other forums also showed commitment to integrating clinical supports, such as the Physical and Nutritional Management Team (PNMT), the quarterly psychiatric clinics, and effort to address an infectious outbreak on campus. However, there were still a number of areas where this integration was not apparent, and work was still needed. Some examples of areas where clinical integration had not yet matured were the development and implementation of IHCPs for at-risk individuals as part of the annual ISP process, efforts related to reducing the need for pre-treatment sedation, and attendance of necessary clinical staff at ISP meetings, particularly dental and pharmacy staff. Significant consults also were reviewed during the provider morning meeting. There was also tracking of consult reports to determine review by the Primary Care Practitioner and appropriate implementation of recommendations. The Facility was found to be in substantial compliance with Section G.2.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>G1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.</td><td>A sample of provider morning meeting minutes was submitted. The dates of these meeting minutes were from 12/9/13 to 12/13/13. Specific staff and departments were tracked for percentage attendance. The following information was obtained from the submitted information for this time period:

<table>
<tr><th>Department</th><th>Number of Days Attended</th><th>Department</th><th>Number of Days Attended</th></tr>
<tr><td>Nursing administration</td><td>1</td><td>Infirmary</td><td>Not applicable (N/A)</td></tr>
<tr><td>Hospital Liaison</td><td>See below*</td><td>Infection Control</td><td>5</td></tr>
<tr><td>Physical and Nutritional Management Team (PNMT)/Habilitation therapy</td><td>5</td><td>RN Case Manager</td><td>5</td></tr>
<tr><td>Qualified Intellectual Disabilities Professionals (QIDP)</td><td>5</td><td>Direct Support Professionals (DSP)</td><td>0</td></tr>
<tr><td>Dietary</td><td>0</td><td>Quality Assurance/ Quality Improvement (QA/QI)</td><td>5</td></tr>
<tr><td>Chaplain</td><td>0</td><td>Pharmacy</td><td>5</td></tr>
<tr><td>Psychology</td><td>5</td><td>Psychiatry</td><td>3</td></tr>
<tr><td>Dental</td><td>3</td><td>Medical</td><td>5</td></tr>
<tr><td>Incident Management</td><td>0</td><td>Medical Compliance RN</td><td>5</td></tr>
</table>
*The Hospital Liaison Nurse position was vacant during this week.

It was noted that the Medical Department had a process to document departmental attendance per month. Data the Facility presented as examples included the months of August 2013 and October 2013. From September 2012 through August 2013, a summary score of expected departmental attendance per month had been tracked. For the prior six months, the data consistently indicated attendance at about 94 percent. This appeared consistent from month to month.

Although minutes and handouts from the provider morning meetings the week prior to the Monitoring Team's visit were requested, an alternate week was</td><td>Noncompliance</td></tr>
</table>

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		provided. The following information summarizes the contents of the provider morning meeting minutes for the week of 12/9/13 through 12/13/13: ▪ The number of meeting minutes totaled five. ▪ Five of five (100%) meetings recorded attendance. ▪ 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. ▪ Five of five (100%) minutes included a report of hospital admissions (normally completed by the Hospital Liaison Nurse). For two reports, all hospitalized individuals were reviewed. For three reports, two of three hospitalized individuals were discussed. ▪ 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 this one set of meeting minutes. ▪ One of five minutes included discussion of results of an open record review. ▪ One set of meeting minutes included additional information provided through a Medical Director announcement. One set of meeting minutes included additional information provided through the Pharmacy Department. One set of meeting minutes included additional information provided by the PNMT. ▪ Three of five meeting minutes included discussion of new issues needing closure and resolution of closure items. There was closure of one item/concern. ▪ One set of meeting minutes indicated the group reviewed ISPAs as part of the closure process. A total of two ISPAs were reviewed. The acceptance or rejection of the ISPAs was not clear according to the meeting minutes. The following was the Monitoring Team member's interpretation of the minutes: o The provider morning meeting group approved zero of two ISPAs as addressing the concern directed to the IDT. o Two of two ISPAs were returned to the IDT for further review to address the concern. ▪ Three meeting minutes documented review of consult reports, as well as whether scheduled consults were not completed. A total of 18 consults were reported or updates provided as to status of the consultation. ▪ One set of meeting minutes recorded a PNMT report/results of a PNMT meeting. ▪ Two meeting minutes included information the Dental Department provided.	

#	Provision	Assessment of Status	Compliance
		▪ Three meeting minutes included an update from the Infection Control Nurse. ▪ One set of meeting minutes recorded updates concerning individuals having medical/dental restraints. ▪ One set of meeting minutes recorded a skin integrity report. ▪ Zero meeting minutes recorded a report of any individuals with significant weight gain or loss other than hospitalized individuals. ▪ Zero meeting minutes included a discussion/in-service of systemic medical concerns, policies or procedures, quarterly analyses of data, etc. The Facility submitted ISPAs generated for hospitalizations that occurred during the six months prior to the Monitoring Team's visit. Documents were reviewed for post-hospitalization ISPAs involving 36 individuals. For 30 of 36, the ISPA was post-hospitalization. For six of 36, the ISPA was to review an ER visit or outpatient procedure result. The 36 ISPAs were reviewed to determine the reason for hospitalization/ER visit, or response to test results, evidence of an Interdisciplinary Team (IDT) 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. These ISPAs were not necessarily the initial ISPAs, but were the ISPAs approved through the provider morning meeting process. One or more individuals had more than one hospitalization, and the Monitoring Team's review did not separate out the various admissions per individual, but all documentation in each ISPA related to the hospitalization/ER visit/procedure results was used to monitor the quality of the team approach to resolving health care issues to address the cause of the hospitalization or repeat hospitalization. Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDTs did demonstrate one or more processes in a number of cases. A review of the 36 ISPAs identified the following findings: ▪ Sixteen of 36 (44%) provided evidence of PCP presence/participation during the ISPA. It was noted that for two of the 36 ISPAs, attendance rosters were not submitted. For the ISPAs in which PCPs did not attend, it could not be determined whether the PCP was off-duty that day, was called to an emergency, had a conflicting meeting, etc. The sample reviewed was spread over several months, and a comparison of recent PCP participation to the earlier months was not made. It is recommended that the Facility determine an acceptable threshold percentage of attendance by PCPs at post-hospital ISPAs, and track each PCP to determine compliance with this	

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		threshold. To improve attendance, this might require added coverage by other PCPs while the PCP attends the scheduled post-hospital ISPA. ▪ The IDT met and developed an ISPA within five days of the hospitalization, ER visit, or procedure completion in 32 ISPAs. For two, the timeliness was not applicable. For one, the date of the hospitalization/ER visit/procedure was not provided in the ISPA. These three were removed from the sample size. Thirty-two of the remaining 33 (97%) of the ISPAs occurred within five days of the discharge date of hospitalization/ER visit/procedure date. ▪ The IDT documented new triggers or early signs/symptoms in seven of 36 ISPAs. ▪ The IDT identified the need for increased monitoring in one or more aspects of care in 12 of 36 ISPAs. ▪ The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 13 of 36 ISPAs. ▪ The IDT identified the need for consultations in 12 of 36 ISPAs. ▪ The IDT identified the need for tests/procedures in six of 36 ISPAs. ▪ The IDT identified the need for additional treatments or a change in treatment in 12 ISPAs. ▪ Thirty-three of 36 ISPAs included one or more of the above interventions. This provided evidence of an efficient mechanism in place to address change in status as evidenced by hospitalizations and ER visits, with interdisciplinary input and cooperation in providing additional preventive steps and treatment in a timely manner. The provider morning meeting documented the quality and timeliness of the IDTs' responses in creating and submitting ISPAs to meet the clinical needs of the individuals that had been hospitalized or gone to the ER. The Medical Department submitted documentation of closure to provider morning meetings for up to 60 days prior to the Monitoring Team's visit. For the time period October 1, 2103 through November 12, 2013, documents including the provider morning meeting minutes and follow-up documentation until closure were provided. Open record reviews, post-hospital ISPAs, and other information regarding identified concerns needing closure were provided, including the evidence used to determine closure. These submitted documents were reviewed with the following results: ▪ Fifteen open record reviews were assigned. One was pending, because the due date was after the time period of the documents submitted. Fourteen open record reviews were submitted indicating closure. All 14 (100%) were presented at the provider morning meeting. For one individual, the record review was completed and presented at the provider morning	

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		meeting, but a procedure was ordered that had not been completed as of the presentation. There was no follow-up in the subsequent morning meeting minutes regarding whether this test had been scheduled. It was unclear how an ordered test was tracked to completion following an open record review. Not all Medical Department tracking systems were part of the provider morning meeting. There was an appointment tracking system in place, and tracking of this test might have been done through this other database. ▪ There were 32 ISPAs tracked during this time period. There was one ISPA, which occurred within five days of hospital discharge, but there was need for further information, which was not due until after the submitted time period. There were eight ISPAs, which were not timely and remained without closure during the time period submitted. Eight of these were from October 2013. If ISPAs were not completed in one month, they were tracked through serial months until closed. ▪ There were two ISPAs in which delays were noted due to the Facility's understanding of the communication from the State Office that use of pre-treatment sedation was on hold. These delays were based on the new psychiatrist's interpretation of regulations concerning this aspect of medical care. This was clarified through the State Office as not a concern, but for undetermined reasons, LBSSLC was not aware of resolution of this concern, and two appointments were delayed from the ISPA process. However, until the Monitoring Team brought this to the State Office's attention, the State Office was not aware of the continued delay, which was then reportedly was resolved quickly. ▪ There were 24 other concerns, which were tracked to closure during this time period. Sixteen of 24 provided evidence of closure during this time period. At the time of the submitted data, eight did not have evidence of closure, according to the log or attached documentation. Two involved potential delays based on an interpretation that the State Office placed a hold on pre-treatment sedation (these reportedly were also quickly resolved once the State Office communicated with LBSSLC). One ISPA had no evidence of follow-up submitted for an acute care nursing plan. For two, an appointment was scheduled, but the submitted information did not indicate if it had been completed. These might have been tracked through the appointment database tracking system. For one, there appeared to be no decision process concerning the use of general anesthesia for a procedure, because there was no information submitted concerning referral to the IDT. For two individuals, consent was still pending before testing could be completed. For one of these two, there was a process for follow-up for the lack of consent, and for the other, there was no	

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		information in the tracking document submitted. In summary, for 24 concerns, 16 were closed during this time period. Of the eight that remained open, there were three, which lacked next steps in the submitted documentation (i.e., one acute care plan, one decision process concerning general anesthesia, and one consent process). Therefore, of the 24, for 21 (88%) had closure or next steps identified. It was noted that all concerns needing closure were followed month to month until closed, which was recorded by a closure date pending written evidence of closure. For easy tracking, a column in the closure-tracking table was used to record the closure date. When closure did not occur, it was obvious due to a blank column. Overall, the system of closure evidence was thorough. ▪ The Medical Compliance Nurse reviewed consultations and procedures that were missed. If repeated attempts did not resolve the issue, the IDT was asked to review and submit an ISPA to address the issue. The provider morning meetings were one forum in which integrated clinical services were demonstrated. As discussed above, this system was well-developed. However, in order for integrated clinical services to be effectively implemented, collaboration between disciplines needed to be evident in a variety of forums. The following were other examples of integrated care that was occurring at LBSSLC: ▪ The quarterly psychiatric reviews showed involvement of a number of disciplines and good collaboration between behavioral health services and psychiatry. ▪ The Physical and Nutritional Management Team provided another example of disciplines working together to develop integrated clinical services for individuals served. ▪ The Infection Control Corrective Action Plan related to individuals with C-Diff showed a team effort amongst clinical as well as nonclinical staff. However, the following were examples of where more work was needed to achieve integrated clinical services: ▪ Although improvements had been seen in clinical staff's attendance at ISP meetings, pharmacy and dental had low attendance at these meetings. ▪ Based on reviews of Integrated Health Care Plans included in recently developed ISPs, they generally showed minimal integration of clinical supports. Many disciplines' plans were not integrated together into the IHCPs, including, for example, medical, psychiatry, psychology, habilitation therapies, and those that were included in some manner, such as nursing, were incomplete. It was particularly important for individuals identified as being at-risk for this integration to occur and be evident in the plans developed to support them on a daily basis, and not just after a	

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		hospitalization or ER visit. ▪ Adequate integration of clinical supports also was lacking in the development and implementation of desensitization plans or other strategies to reduce the need for pre-treatment sedation. In summary, the Facility had made progress with regard to the provision of integrated care, particularly through its provider morning meeting processes. Some other forums also showed commitment to integrating clinical supports. However, there were still a number of areas where this integration was not apparent, and work was still needed. State Office had not yet issued a final policy in this regard, and such guidance was needed. 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 submitted consultant reports for one individual from each residence, as well as any Integrated Progress Notes (IPNs) commenting on the consultant reports. Consultations for 15 individuals were submitted, with a range of two to six consultations per individual. A total of 59 consultant reports were submitted and these are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 59 reviewed, 56 (95%) included the PCP initials/signature, indicating review by the PCP. ▪ Of the 59 reviewed, 56 (95%) included the date on which the PCP conducted the review. ▪ Of the 59 reviewed, 56 (95%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these, 52 of 59 (88%) included submission of PCP IPN entries as was required by the Medical Care Policy. ▪ No ISPAs were submitted that 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. A QIDP representative attended the provider morning meeting, who provided additional communication to the IDT needing to take action, if additional clarification was needed. Review of information from the provider morning meetings showed this system was working.	Substantial Compliance

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; and 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, for the following individuals: Individual #230, Individual #75, Individual #53, Individual #116, Individual #254, Individual #310, Individual #282, Individual #21, Individual #113, Individual #108, Individual #320, Individual #77, Individual #68, Individual #154, Individual #214, and Individual #259. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; and o Leah Shultz, RN, BSN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: internal and external medical provider quality assurance audits, internal and external medical management audits, and quality clinical indicator monitoring audits. o These monitoring/audit tools included some 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 focus on specific areas needing improvement. o The monitoring tools included adequate methodologies, such as record review. 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 size(s) were adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: Medical Compliance RN, RN Clinic manager, and PCPs. o For the completion of the tools for the internal medical management audits, adequate inter-rater reliability had been established between the various Facility staff responsible. ▪ The Facility used other relevant data sources and some key indicators/outcome

	measures to show whether or not the intended outcomes of the Settlement Agreement are being reached. Numerous databases were being utilized. The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility presented some of the data in a meaningful/useful way, but some 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. ▪ The Facility rated itself as being in substantial compliance with Section 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 some analysis of the information, identifying, for example, clinical indicators in the medical provider quality assurance audit that needed improvement.
	Summary of Monitor's Assessment: LBSSLC continued to demonstrate progress with regard to Section H. The morning meetings provided oversight to acute change of health status concerns for individuals that were hospitalized or had gone to the Emergency Room. There was an internal medical quality improvement system, which included the completion of many audits. The audits provided oversight to maintenance of quality and standards of care. Numerous clinical indicators were included in the audits, and results were available for each of these. Additionally, the medical provider quality assurance audits and medical management audits, along with the provider morning meetings, provided monitoring of health care. The Facility's current practices largely related to the implementation of clinical guidelines that indicated which steps should be taken in the assessment/evaluation and order process, and did not provide a method for assessing whether or not treatments and interventions were provided as prescribed, and if so, if they had the intended effect. It will be important for the system to mature to a point where, using clinical indicators, the efficacy of treatment is reviewed for individuals as well as on a more systemic level, and that this information is used to make changes or take corrective action, when issues are identified. For example, the internal quality review should demonstrate monitoring of response to abnormal physical findings and lab/test results to determine timely and appropriate response by the PCPs. In addition, the at-risk system should continue to mature into a quality process, which demonstrates the full spectrum of health monitoring. It will be essential for the Facility's system to include indicators across all clinical disciplines, and not just those the Medical Department typically monitors. The Facility was found to be in substantial compliance with Section H.2.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months	Based on submitted documents, several routine and periodic assessments were	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>reviewed for timeliness for several clinical departments. These included the following:
One hundred forty of 198 (71%) medical annual assessments were completed in a timely manner. For 19 of the most recent medical annual assessments, completion within 365 days of the prior assessment occurred in 15 of 19 (79%). A review of eight active records indicated that a medical annual assessment had been completed in the last 365 days in eight of eight (100%).
Sixty-seven of 81 (83%) annual dental evaluations were completed in a timely manner.
During the past two quarters (i.e., May through November 2013), 218 of 218 (100%) Quarterly Drug Regimen Reviews (QDRRs) were completed by the Pharmacy Department in a timely manner.
Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. Based on information included in the Presentation Book for Section H, the following reflects the clinical departments' compliance with timely submission of assessments for the ISP process:<table><tr><th>Department</th><th>May 2013</th><th>June 2013</th><th>July 2013</th><th>August 2013</th><th>September 2013</th><th>October 2013</th></tr><tr><td>Dental</td><td>78%</td><td>81%</td><td>81%</td><td>94%</td><td>44%</td><td>53%</td></tr><tr><td>Medical</td><td>89%</td><td>100%</td><td>81%</td><td>94%</td><td>94%</td><td>88%</td></tr><tr><td>Psychiatry</td><td>100%</td><td>90%</td><td>100%</td><td>100%</td><td>75%</td><td>89%</td></tr><tr><td>Nursing</td><td>17%</td><td>38%</td><td>69%</td><td>33%</td><td>63%</td><td>41%</td></tr><tr><td>Occupational Therapy/ Physical Therapy (OT/PT)</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Speech</td><td>90%</td><td>91%</td><td>100%</td><td>100%</td><td>100%</td><td>90%</td></tr><tr><td>Psychology</td><td>83%</td><td>94%</td><td>75%</td><td>94%</td><td>94%</td><td>82%</td></tr><tr><td>Nutrition Services</td><td>100%</td><td>94%</td><td>94%</td><td>100%</td><td>100%</td><td>94%</td></tr></table>This demonstrated that the clinical departments were tracked for completion of required documents for the inter-disciplinary process in a timely manner. There was a wide range of compliance, depending on the department. OT/PT services and Nutrition services were over 90 percent. Medical, psychiatry, and speech therapy services approached the 90% percent compliance threshold. For dental, nursing,</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		and psychology services, this area remained a challenge. The Facility remained in noncompliance with this provision.	
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 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 if 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.). Evidence for diagnoses for 16 individuals was submitted. For 64 of 64 (100%) diagnoses submitted with supportive documentation, the criteria listed were consistent with the diagnosis listed. 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 Assessments and updates, annual Psychiatric Medication Treatment Plans, and ongoing quarterly updates for everyone prescribed psychotropic medication, the Facility had maintained the improvements in its diagnostic practices related to psychiatric disorders. LBSSLC remained in compliance with this provision.	Substantial Compliance
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.	As a measure of timely quality treatment/interventions, the Medical Department utilized several mechanisms to ensure timely, quality intervention and treatment. The provider morning meeting was an inter-disciplinary forum to address change of status of individuals as problems arise. Change of status as defined through hospitalizations and ER visits was discussed the next business day, with several routes to ensure timely intervention/treatment. Discussions among the PCPs provided feedback concerning quality care. An open record review was completed on hospital admissions to review timely treatment, as well as quality of care of the appropriate clinical disciplines. This information was discussed at the provider morning meeting as a follow-up. For those individuals hospitalized, a post-hospital ISPA process was required and presented at the provider morning meeting within five days of assignment. The quality of the ISPA, with focus on quality preventive steps, was reviewed for each ISPA, as applicable. For those not meeting this requirement, the ISPA was returned to the IDT for further review. There were other clinical concerns that did not fit into the category of a post-hospital ISPA or an open record review, but were concerns discussed at the	Noncompliance

#	Provision	Assessment of Status	Compliance
		provider morning meeting. These were then assigned for review and resolution, and were brought back to the provider morning meeting for closure. Due dates were assigned to open record reviews, post-hospital ISPAs, and concerns needing closure. These were tracked until written documentation was provided for closure. Significant consult reports were reviewed, as well as areas affecting quality of care, such as repeat refusals for specialty appointments or lab testing. All these areas were tracked, and discussed at the provider morning meeting. The participants of the provider morning meeting provided both the quality information and guidance to these various interventions (e.g., open record reviews, ISPAs, etc.). The provider morning meeting was an efficient, daily monitoring forum to ensure quality and timeliness of the clinical issues discussed there. Another approach to ensuring quality treatment and intervention was the follow-up of results of the external and internal medical management audit. An internal audit was completed for every quarter. Internal medical peer review general and medical management audits were completed in May, August, and November 2013. External audits were completed in August 2013. Compliance per PCP is further discussed with regard to Sections L.2 and L.3. It was noted there was also a measurement of timeliness in response to areas not in compliance and completion of corrective action plans. The QA nurse reviewed the active records for evidence of corrective action at approximately 30-day intervals. There appeared to be a delay in responding to the corrective action plans from the May 2013 internal medical peer review audits, but improved timeliness was demonstrated with the August and November corrective action plans. This improved response also indicated the process of quality improvement was in place. Discussion related to Sections L.2 and L.3 provide more detailed information. Although improvements were seen with regard to the provision of timely clinical care, concerns continued to exist. These are discussed in greater detail with regard to other sections of the report. However, in summary, the integrated process for addressing individuals' at-risk issues reflected progress with some teams and less progress with others. As discussed in further detail with regard to Section I, some individuals received timely treatment and interventions while others did not. Although IHCPs included some timelines for the provision of care and treatment, many components of IHCPs continued to be missing, making measurement of timely completion difficult. In addition, the Facility did not yet have a good system for reviewing individuals' IHCPs on a monthly basis, and determining if needed treatment and interventions had been provided as specified. As is also discussed with regard to Section M, nursing interventions were not consistently documented in IPNs, and as a result, timely implementation was difficult to measure. Discussion related to Section O, also illustrates the Facility's continuing struggle to measure the	

#	Provision	Assessment of Status	Compliance
		provision of interventions the PNMT recommended. The Facility had made some progress in this area, but remained in noncompliance. A system is needed to measure the timely provision of clinical care across disciplines.	
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.	LBSSLC had two systems in place in which clinical indicators were used to measure quality of care. The internal and external medical management audits focused on six diagnoses, and these are reviewed with regard to Sections L.2 and L.3. Additionally, the Medical Department created a number of additional quality medical care monitoring tools with specific measurable indicators. Choice of clinical areas focused on the needs of the individuals residing at LBSSLC. Some areas were chosen because of increased frequency and others due to the unique comorbid conditions of the population. A new tool was created for Gastroesophageal Reflux Disease (GERD), as it was determined that 110 of 211 (52%) individuals had a diagnosis of GERD. Five of 211 individuals were determined to have a diagnosis of Ogilvie syndrome, and this was chosen for auditing to ensure optimal care. A copy of the tools was submitted. The audit tools were concise, and focused on basic expectations of clinical management of these conditions. There were four additions to the internal QA review since the last Monitoring Team review: GERD, Ogilvie syndrome, Urinary Tract Infection (UTI), and Tuberous sclerosis. Reference materials in creation of the clinical indicators included "Agency for Healthcare Research and Quality (AHRQ)," "Up to Date," and "Texas Clinical Guidelines." There were five quality indicators for review of GERD, six quality indicators for Ogilvie Syndrome, five quality indicators for UTI, and three quality indicators for Tuberous sclerosis. The Medical Department continued to expand monitoring of clinical care to additional diagnoses present in the population residing at LBSSLC. The quality medical care monitoring tools used specific measurable indicators that measured compliance with standards of care, such as frequency of completing a Hgb A1C in an individual with diabetes, or whether there was evidence that a podiatry exam was completed annually for an individual with diabetes. Measurements of the efficacy of treatment also should reflect the health of the individual or the population of individuals at LBSSLC. Efficacy of treatment across the audit sample should reflect how many/percentage of individuals having a diagnosis of diabetes mellitus have an Hgb A1C at a specified level or below that level. How many diabetics developed skin breakdown/ulcers/infection of the feet in the past year? For those with GERD, a clinical indicator was whether the individual was on a caloric restriction if overweight. This did not encompass the	Noncompliance

#	Provision	Assessment of Status	Compliance
		effectiveness of treatment. An indicator that would reflect this aspect of care would be the percentage of individuals with GERD that were overweight and on a therapeutically restricted/low calorie diet that subsequently lost weight in the past six months or 12 months. These examples highlight the need for interdisciplinary collaboration and cooperation. The PCP can order the various tests at required frequencies, but if the individual is noncompliant with diet, this might need further review by psychology, dietary, and residential staff. If the individual were refusing medication, then a different mix of professionals would need to meet to determine options. If the individual has GERD, is overweight, and is noncompliant with diet, the same issues arise. The results of the various quality assurance audits indicated that most individuals had received the standard of testing and consultations needed for specific diagnoses. That is an important first step in the quality care process. However, providing medical direction is dependent on data that can measure the health of the individuals. The Facility needed to put processes in place to measure the efficacy of treatments. The Facility should develop clinical indicators across the range of clinical interventions. As discussed in previous reports, the individualized IHCPs (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. In its Self-Assessment for Section H.4, the Facility referenced some key indicators. Although it was positive that the Facility had begun to collect some data on key indicators, many of these were demographic in nature (i.e., how many individuals had a particular diagnosis, such as diabetes; or how many events occurred, such as hospitalizations), or they assessed whether certain evaluations were completed (e.g., Dexa scans, foot evaluations for individuals with diabetes, etc.). Very few looked at the efficacy of treatment (e.g., number of individuals with complications from diabetes, number of individuals with bowel obstructions, or number of individuals with aspiration pneumonia), and these only looked at the ultimate bad outcome, as opposed to taking a more proactive approach to looking at the efficacy of treatment. The Facility remained in noncompliance with Section H.4.	

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<tr><td>H5</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.</td><td>The internal quality monitoring tools were used periodically to audit a number of specific diagnoses or medical events for which treatment was provided at LBSSLC. The RN Clinic Manager completed an audit of a sample of records for each of the clinical categories/conditions. The Medical Compliance Nurse reviewed the results to confirm answers and provide corrections as applicable. The Medical Director then reviewed results, conducted analysis, and determined any trends. The Medical Director then provided individual guidance to the PCPs to improve compliance. Additionally, if trends were noted, a medical staff meeting was called to review results and provide direction for corrective actions on a systemic level. The number of audits per year, per topic were as follows:

<table>
<tr><th>Topic</th><th>Annual sample size</th><th>Number of audits per year</th><th>Topic</th><th>Annual sample size</th><th>Number of audits per year</th></tr>
<tr><td>ER/ hospital admissions</td><td>20%</td><td>24</td><td>Constipation</td><td>20%</td><td>16</td></tr>
<tr><td>Seizures</td><td>20%</td><td>17</td><td>Diabetes mellitus</td><td>100%</td><td>13</td></tr>
<tr><td>Metabolic syndrome</td><td>100%</td><td>6</td><td>Down Syndrome</td><td>100%</td><td>4</td></tr>
<tr><td>Osteoporosis</td><td>20%</td><td>13</td><td>Tuberous sclerosis</td><td>100%</td><td>1</td></tr>
<tr><td>Prader Willi syndrome</td><td>100%</td><td>1</td><td>Pneumonia</td><td>20%</td><td>4</td></tr>
<tr><td>Ogilvie syndrome</td><td>100%</td><td>5</td><td>GERD</td><td>20%</td><td>22</td></tr>
<tr><td>UTI</td><td>20%</td><td>3-4</td><td></td><td></td><td></td></tr>
</table>

Details of the clinical quality Monitoring Tools are reviewed with regard to Section L.3, along with results of findings. Numerous examples of completed reviews were submitted as evidence of ongoing audits. These internal, periodic reviews represented quality review of timely assessment/testing, treatment, and intervention. The purpose of these audits was to identify these areas, to educate the PCPs on applicable corrective actions, and to repeat audits at intervals to demonstrate improvement. This program effectively monitored the quality treatment of these diagnoses common to individuals at LBSSLC.

As most of the results were 100 percent compliant, this indicated that based on the Facility's self-assessment, quality care was being provided for individuals with diagnoses covered by each of the audits. As discussed below, given that the</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Monitoring Team was continuing to find concerns with regard to quality of care, these ratings might not have been accurate. Maintenance of quality is an important, and often overlooked, component of care, and these audit tools were a tool to assist the Facility in this maintenance of quality. Additionally, there were three new monitoring tools added as an internal quality review by the Medical Department in the past year (i.e., Ogilvie syndrome, GERD, and UTI). A working QI process included identifying areas of concern that need improvement, followed by in-service and other training mechanisms or corrective actions, as indicated, and a follow-up after a period of time to verify impact of the in-service training or other corrective steps taken. For many of the current clinical indicators, compliance was 100 percent. Given that based on the Monitoring Team's review, issues continued to be identified, one interpretation is that the clinical indicators were not sensitive enough to detect areas needing improvement, or that the clinical indicators reflected quality care if there was a reduction of change of status due to these conditions. The tools should be sensitive enough to identify proactively areas in which further evaluation or assessment are needed, or different treatment options should be considered. The Medical Department is encouraged to review areas of ongoing challenge or areas that have been identified as concerns, and create monitoring tools to assess these areas, followed by analysis, and, as appropriate, training or other corrective actions, and follow up evaluation to determine impact on improvement. There are several areas defined in this report where this would apply, and the Medical Department is encouraged to review Section L for areas of concern. This would allow focus for continuing improvement as well as verification of maintenance of quality. As a measure of periodic ongoing reviews, the Medical and Pharmacy Departments completed quarterly reviews of all individuals. One hundred eighty five of 198 (93%) active medical records included current medical quarterly notes. Two hundred eighteen of 218 (100%) QDRRs were current. These two processes reviewed component of individuals' health status on an ongoing basis. As a separate focus from ongoing continual monitoring efforts at periodic intervals, an efficient system had been developed and implemented for acute changes of health status, as defined by hospitalizations and ER visits. For acute care, the provider morning meeting each business day provided an up-to-date review of health status changes for those individuals on campus for whom PCPs had been involved, as well as those hospitalized. This was done through the on-call PCP report, a review of the 24-hour log, and the Hospital Liaison Nurse report. The handouts and minutes provided written documentation of review and discussion of each case. All acute change of health status was reviewed at the provider morning	

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meeting through one of the above processes.

Additionally, open record reviews were assigned and reported at the provider morning meeting. This allowed rapid feedback of the events leading to hospitalization, including the quality of nursing monitoring and assessment, and a review of PCP assessment, interventions, orders, and review of lab tests and other data. The following indicated the number of open record reviews assigned and completed through the provider morning meeting process:

<table>
<tr><th>Month</th><th>Number of open record reviews completed</th><th>Month</th><th>Number of open record reviews completed</th></tr>
<tr><td>May 2013</td><td>8</td><td>August 2013</td><td>7</td></tr>
<tr><td>June 2013</td><td>6</td><td>September 2013</td><td>8</td></tr>
<tr><td>July 2013</td><td>5</td><td>October 2013</td><td>8</td></tr>
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This was one tool to effectively measure the quality and timeliness of acute care intervention for change of health status.

Post-hospital ISPAs were tracked through the provider morning meeting. Some individuals had more than one ISPA entry in the tracking log for various reasons (e.g., repeat hospitalization, ISPA needed to be reviewed again by the IDT, etc.). These represented acute care issues following hospitalization. The following indicates the number of ISPAs tracked per month through the provider morning meeting:

<table>
<tr><th>Month</th><th>Number of ISPAs tracked</th><th>Month</th><th>Number of ISPAs tracked</th></tr>
<tr><td>July 2013</td><td>20</td><td>October 2013</td><td>16</td></tr>
<tr><td>August 2013</td><td>12</td><td>November 2013</td><td>4</td></tr>
<tr><td>September 2013</td><td>13</td><td>December 2013</td><td>11</td></tr>
</table>

Although the Medical Department components of a Facility-wide system to monitor and assure health and safety were in place for acute change of health status, and many aspects of maintenance health care, the at-risk system was an additional
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#	Provision	Assessment of Status	Compliance
		Facility-wide system with continued demonstrated need for growth and development. Needed improvements with regard to the ISP process, including incorporation of quality IRRF information and development of comprehensive IHCPs had not yet occurred. As a result, the Facility did not have a system in place to consistently and proactively measure individuals' health status. In addition to tracking change of health status through the provider morning meetings, an additional component of health status measurement data needs to be developed. This component would reflect maintenance of health. Examples would include: the percentage of individuals within ideal body weight, as well as those less and those over that range for each quarter; the percentage of individuals with osteoporosis for whom the last two DEXA scans indicated improvement or stabilization of the T score; the percentage of individuals with a diagnosis of bipolar disorder that did not require restraints (physical, mechanical, chemical) in the prior quarter; the number of individuals with a seizure disorder with no seizures in the past quarter, one seizure in past quarter, etc.; the number of individuals with a diagnosis of chronic constipation that required additional interventions beyond routine daily medication (prn medications); the number of individuals with a target behavior of SIB with 10%, 25%, etc. less SIB events the past quarter compared to the prior quarter; and for those with fall prevention plans, the number of individuals that had no fall versus fall without injury, versus fall with injury in the past quarter. Tracking the actual health status would allow determination of effectiveness of systems in place (e.g., medical treatment, behavioral plans, dining plans, risk plans, such as fall prevention, etc.). It would allow determination of the health of individuals residing at LBSSLC.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	For compliance with this subsection, the Medical Department needed to demonstrate creation of audit tools with clinical indicators focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (e.g., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit should measure whether there was evidence that change occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, need for further consultation, or need for further lab testing, scans, etc. Most of the indicators required a PCP order, and, therefore, were clinical in nature and focused on completion of a minimum set of monitoring or assessment/evaluation steps nationally recognized as reflecting ongoing quality of care for specific diagnoses, but did not take this next step of monitoring results of treatment and interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The focus of this section is providing a quality improvement process that tracks medical care response to abnormalities in test results, or clinical findings. As one approach to demonstrating compliance in this area, the Medical Department is encouraged to further review clinical indicators based on lab and radiographic findings, and to provide an audit mechanism to review the appropriateness and timeliness of the PCP response to abnormalities. The data the Facility provided did not specifically address change in treatment (i.e., frequency or type of lab tests, change in medication, change in dosage, additional medication, additional consults, etc.), based on the clinical indicators used. In most instances, the clinical indicators focused on routine treatment expectations, such as frequency of Hemoglobin A1C (Hgb A1C) in diabetes mellitus or whether periodic specialty consultations were obtained. The quality indicators were not sensitive enough to measure responsiveness and timeliness of responsiveness to abnormal lab and test results, or other changes in clinical status. The requirements for this subsection focus on preventive care/maintenance care, and do not relate solely to demonstration of responses to individuals' acute care needs. For instance, if a Dilantin level was returned as abnormally high or low, was the PCP response appropriate and timely? If the database indicated five abnormal Dilantin levels across campus in the month, was there a quality improvement process in place to track the PCP response and timeliness to the abnormalities? When data was reviewed related to acute care interventions to abnormal Dilantin levels, was there a trend, and what were the steps taken (i.e., training, etc.) to improve care, followed by further tracking of this information for indications of resolution? Similarly, if a Complete Blood Count (CBC) result indicated abnormally high or low hemoglobin, did the PCP modify treatment or order additional tests? Were the treatments or tests appropriate (as based on specific standards), and was the response timely? This approach answers a different set of clinical questions than many of the current clinical indicators. This would require a revision of some of the clinical indicators to reflect changes in treatment. Such a system would need to not only incorporate clinical indicators for the Medical Department, but across clinical disciplines. The Facility remained in noncompliance 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	The provider morning meeting policy "Morning Provider Meeting – Integrated Clinical Services" defined the process of how information concerning acute change of status was discussed in a timely manner and the representation from various clinical departments. The change of status reflected in hospitalizations was followed by an open record review, as well as development of an ISPA to discuss	Noncompliance

#	Provision	Assessment of Status	Compliance
	integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	health and safety, with additional focus on prevention of repeat hospitalizations. The quality was monitored by the interdisciplinary membership of the provider morning meeting. Additionally, timeliness of completion was tracked. The QIDP Coordinator or designee attended, and brought concerns back to the appropriate QIDP and IDT to initiate the process, or to review the ISPA, if the ISPA was found inadequate by the provider morning meeting group. Changes in risk would be included in the decisions the IDT made. Additionally, the ISP process had undergone a number of revisions and was in a training phase. The Facility was tracking specific indicators of progress in creating quality ISPs through such statistics as percentage of individuals with current risk ratings, percentage of change of status ISPAs with clinically appropriate recommendations, implementation of quality indicators of the IRRF data, discussion and accuracy of risk ratings, quality of the IHCP, and integration of the risks and IHCP into the ISP. Although much has yet to be achieved, it appears there was a pragmatic blueprint in place, which should allow for attainment of integrated clinical services. It is a positive step that the Facility has seen the provider morning meeting as integral in ensuring acute changes of health status were aggressively evaluated and treated in a timely manner as an important early step in the Facility-wide risk process and ISP/ISPA development. It is also important to note the need for several other future steps such as incorporating the Direct Support Professional Treatment Observation Record (TOR) into the IHCP process, encouraging attendance by the individual and direct support professionals at the ISP meeting, tracking PCP attendance at Change of Status (COS) ISPAs, and determining the quality of the departmental annual assessment. As discussed throughout this section of the report, more work was needed to develop and implement a system to address minimum common elements of clinical care. The State Office should finalize a policy in this regard, and the Facility's policies and procedures should be supplemented and/or modified to incorporate the full scope of a system designed to ensure the provision of these minimum common elements of clinical care.	

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 #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues; and o From the individuals' active record, selected documents, including: 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 past one year, ER report past one year, consults and procedure reports past one year, Do Not Resuscitate (DNR) forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form past one year, most recent integrated health care plan for the following individuals: Individual #258, Individual #323, Individual #43, Individual #309, Individual #55, Individual #283, Individual #184, and Individual #242. ▪ **Interviews with**: o Robin Seale, Assistant Director of Programs; o Brandi Villarreal, RN, BSN, Chief Nurse Executive (CNE); and o Lilly Burton, RN, Program Compliance Nurse. ▪ **Observations of**: o ISP Meeting for Individual #178, on 1/7/14; o ISP Meeting for Individual #264 on 1/8/14; and o ISP Meeting for Individual #161, on 1/9/14.
	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 implementing monitoring tools for Section F and re-implementing monitoring tools for Section M that would yield data reflecting issues related to the At-Risk process. 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 Since the last review, a very positive step forward was that the Facility had implemented many of the indicators to assess compliance that the Monitoring Team used for this section. As the Facility continues to revise and implement 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, especially regarding the quality of the documentation. In addition, the Facility should develop adequate instructions to address the 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.) was included with all of the data presented in the Self-Assessment, which facilitated the interpretation of the relevance of the data. In addition, the Facility used a 20% sample size to generate much of the data. This was an adequate sample size that usually renders the data representative of the actual practices being monitored. However, issues related to the lack of inter-rater reliability and the lack of specific criteria to define compliance regarding the quality of the documentation and supports provided need to be addressed in order for the Facility's data to be accurate and reliable. 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 a number of disciplines conducted 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 the appropriate disciplines to review discipline-specific assessments 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 by which to evaluate quality in alignment with

	discipline-specific standards of practice. o As noted above, adequate inter-rater reliability should be established for the final Section I monitoring tool. ▪ Although the Facility had made significant progress in its efforts to monitor and present the data regarding Section I, the lack of specific compliance criteria and the lack of established inter-rater reliability rendered the Facility's data inaccurate and unreliable. 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. o Did not measure the quality of the documentation versus 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 continue its efforts to 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 At-Risk Individuals procedure was revised and finalized. The Facility's Self–Assessment indicated that a review of the training data for the Individual Support Plan – At-Risk Individuals procedure demonstrated that of the 425 staff identified as needing training, 365 staff (86%) received the training. In addition, any newly hired QIDPs were to be trained within the first 30 days of hire. In addition, the monitoring activities regarding the risk processes were resumed. However, they were executed in a different manner than previously in order to integrate other processes and monitoring data from other sections of the Settlement Agreement into Section I. For example, part of the At-Risk monitoring for Section I integrated data related to timeliness and quality for the annual nursing assessments from the Section M monitoring tools. Although this was a very promising step forward, the Facility would need to ensure that data integrated from other disciplines accurately reflected the quality of the documentation reviewed. On a very positive note, since the last review, the Facility had begun using Incident Management data regarding falls and restraint use when evaluating the accuracy of the risk ratings for falls and challenging behaviors. The ADOP reported that in reviewing this information, several individuals with high restraint use or high numbers of falls, some which resulted in injuries, actually had lower risk ratings than appropriate. For these cases, special reviews of the risk levels were requested from the IDTs resulting in appropriate increases in the risk ratings. 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. Much of the Facility's data were promising, in that a standard presentation format appeared to have been established, and relevant information were included, such as the percent sample sizes. In addition, most of the indicators the Facility used since the last review were in alignment with the requirements of the Settlement Agreement, especially initial efforts made to address the quality of the teams' identification of needed assessments, the completion of assessments, and the related documentation. However, considerable more work was needed to address the quality of the documentation, and additional information should be provided regarding what specific criteria were used to determine compliance regarding the quality of the at-risk documentation.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	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 At-Risk Individuals procedure was revised and finalized. The Facility's Self –Assessment indicated that a review of the training data for the Individual Support Plan – At-Risk Individuals procedure demonstrated that of the 425 staff identified as needing training, 365 staff (86%) received the training. In addition, any newly hired QIDPs were to be trained within the first 30 days of hire. ▪ Discussions with the ADOP indicated that since the last review, monitoring activities regarding the risk processes were resumed. However, they were executed in a different manner than previously in order to integrate other processes and monitoring data from other sections of the Settlement Agreement with Section I. For example, part of the At-Risk monitoring for Section I integrated data related to timeliness and quality for the annual nursing assessments from the Section M monitoring tools. Although this was a very promising step forward, the Facility would need to ensure that data integrated from other disciplines accurately reflected the quality of the documentation reviewed. ▪ The Facility's Self-Assessment indicated that data addressing whether or not individuals had current risk ratings from May through November 2013 had been reviewed on a monthly basis, and a problem had been found related to a database issue showing decreases in compliance. However, follow-up efforts found that as of 11/20/13, all the risk ratings were current for all individuals. In addition, a random sample of IRRFs was reviewed each month to determine if the At-Risk policy was accurately being implemented. The Self-Assessment indicated that a sample of 21 from 103 (20%) IRRFs were selected using the fourth ISP from the monthly ISP schedule for each month (May 2013 to October	Noncompliance

#	Provision	Assessment of Status	Compliance

2013). As the data below demonstrated, IDT discussion and rationale for risk ratings continued to be an area where improvement was needed and thus, was included in the Facility's Action Plan addressing this area.

Probe	May 2013	June 2013	July 2013	August 2013	September 2013	October 2013	Overall Compliance
Risk ratings current	100%	33%	100%	100%	100%	75%	85%
Current status has all relevant data	0%	67%	100%	50%	100%	50%	61%
Current supports	25%	33%	100%	25%	100%	75%	60%
Historical data	25%	67%	100%	50%	100%	75%	70%
IDT discussion/ recommendations	25%	33%	100%	0%	33%	50%	40%
Rationale	0%	33%	100%	0%	33%	25%	32%
IRRF current in record	100%	100%	100%	100%	100%	75%	96%

- From the same sample, ISPs, IRRFs, and IHCPs were reviewed monthly to determine if the IDTs integrated the risk process and the IHCP into the ISPs, and integrated the team discussions into the IRRF document. The Facility's data below indicated that compliance regarding this integration continued to be problematic.

Probe	May 2013	June 2013	July 2013	August 2013	September 2013	October 2013	Overall Compliance
Risk is integrated into ISP	0%	33%	0%	0%	33%	50%	19%
IHCP is part of ISP action plan	0%	33%	0%	50%	33%	100%	36%
Evidence of integrated discussion in IRRF	25%	33%	100%	0%	67%	50%	46%
Total Population (N)	18	17	16	18	16	18	103
Sample (n)	4	3	3	4	3	4	21

- Regarding ISP meetings, the Facility's Self-Assessment indicated that data was generated from the monitoring of a 20% random sample of ISPs meetings that were monitored each month except for June 2013, by the QIDP Coordinator and QIDP Educators to assess the implementation of the risk screening process. Ninety days in advance, the Program Compliance Monitor randomly selected a 12% sample of 12 (n) ISPs out of a total of 103 (N) from May through October 2013 from the Facility's monthly ISP schedule (only one monitoring tool was completed for May and July 2013, due to the fact that the Facility was piloting a new monitoring form). However, the Self-Assessment indicated that there were

#	Provision	Assessment of Status	Compliance

significant variations in the compliance scores between auditors, since inter-rater reliability was not established for the tool rendering the data unreliable. The Facility indicated that an Action Plan for Section F addressed the need to establish inter-rater reliability.

- Data from the Facility's Self-Assessment regarding the timely submission of discipline assessments 10 days prior to the ISP meeting from May through October 2013, demonstrated that there were some disciplines that improved or maintained high compliance scores such as Physical Therapy, and the submission of the Preferences Strengths Inventory. However, the Facility indicated that challenges continued to be noted regarding the timely submission of the Nursing Annual Assessments, Self-Administration of Medication Assessments, and the Dental Assessments. However, a current corrective action plan addressing the timeliness of nursing assessments was implemented.

	May	*June*	*July*	*August*	*September*	*October*
FSA	72%	88%	88%	94%	100%	82%
PSI	72%	94%	100%	100%	100%	100%
Psychological Assessment	83%	94%	75%	94%	94%	82%
Psychiatric Assessment	100%	90%	100%	100%	75%	89%
Occupational Therapy	100%	100%	100%	100%	100%	100%
Physical Therapy	100%	100%	100%	100%	100%	100%
Speech	90%	91%	100%	100%	100%	90%
Audiology	100%	100%	100%	100%	100%	100%
Nutrition Services Evaluation	100%	94%	94%	100%	100%	94%
Annual Physical	89%	100%	81%	94%	94%	88%
Annual Nursing	17%	38%	69%	33%	63%	41%
SAMs	0%	0%	25%	28%	31%	18%
Dental	78%	81%	81%	94%	44%	53%
Water Safety	100%	100%	100%	100%	100%	100%

#	Provision	Assessment of Status	Compliance

Vocational	92%	100%	100%	92%	100%	83%
Day Programs	100%	90%	100%	100%	90%	100%
Recreation Summary	94%	94%	100%	100%	100%	69%
Risk Report		100%	100%	100%	100%	100%
Overall Compliance	82%	86%	90%	91%	88%	83%

- In addition, the Facility's Self-Assessment indicated that data regarding the quality of the disciplines' assessments were not available due to the need to "formally structure these reviews across the Facility." Since the last review, the Facility indicated that the focus of the ISP Workgroup shifted to quality issues regarding the assessments and accordingly, appropriately revised the Action Plans to reflect this focus. In addition, a promising quality checklist template was disseminated to all the disciplines and a monitoring tool had been developed at the time of the review, but had not yet been implemented.
- On a very positive note, since the last review the Facility had begun incorporating Incident Management data regarding falls and restraint use when evaluating the accuracy of the risk ratings for falls and challenging behaviors. The ADOP reported that in reviewing this information, several individuals with high restraint use or high numbers of falls, including some that resulted in injuries, actually had a lower risk rating than appropriate. For these cases, special reviews of the risk levels were requested from the IDTs resulting in appropriate increases in the risk ratings.
- Much of the Facility's data were promising, in that a standard presentation format appeared to have been established, and relevant information such as the percent sample sizes were included. In addition, since the last review, most of the indicators the Facility used were in alignment with the requirements of the Settlement Agreement, especially initial efforts made to address the quality of the teams' identification of needed assessments, the completion of assessments, and the related documentation. However, considerable more work was needed to address the quality of the documentation, and additional information should be provided regarding what specific criteria were used to determine compliance regarding the quality of the at-risk documentation.

Self-rating:
The Facility's Self-Assessment indicated 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, completion of quality assessments and the lack of a consistent system which identifies individuals at risk. Action Plans for Section I.1 address issues related to system implementation and improvement in the quality of the IRRF. The ISP Workgroup has action plans in place which

#	Provision	Assessment of Status	Compliance
		address the quality of assessments." The Facility clearly had invested a great deal of effort in reviewing the requirements and their overall systems, monitoring data, and Risk Management data regarding the At-Risk system at LBSSLC. It was clear to the Monitoring Team from discussions with the Assistant Director of Programs that there was a significant increase in the depth of understanding of the complexity and overall purpose regarding the At-Risk process and system. However, the lack of clear documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes for the sample of 23 individuals discussed with regard to Sections I.2, and I.3. Consequently at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress. To assess the Facility's revised risk screening process, members of the Monitoring Team observed three individuals' ISPs meetings (i.e., Individual #178, Individual #161, and Individual #264) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at none (0%) of the observed ISP meetings. Dental staff were not present at any of the three ISPs observed, but should have been. Individual #178 and Individual# 161 both had poor oral hygiene ratings, and had high-risk levels for dental issues. According to the IRRF, Individual #264 "has general anesthesia for exam, DS&RP [deep scaling and root planing], full mouth radiographs, and any restorative work and or [sic] extractions if needed every six months." Also, psychiatry was not present for Individual #264's ISP in spite of the fact that the team had identified the need for psychiatry to be present ▪ 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 all (100%) of the ISP meetings. ▪ The individual was present at one (33%) of the ISPs meetings observed. The QIDP reported that for Individual #264, attempts had been made to facilitate his attendance, however, through his behavior, he had demonstrated that he did not want to attend. In addition, Individual #161 was on isolation at her residence at the time of the ISP. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at all (100%) of the ISP meetings. ▪ The IDT consistently used supporting clinical data when determining risks levels for none (0%) of ISPs observed. There was a lack of supporting clinical data presented at the ISP meetings for Individual #178, Individual #161, and Individual #264, when determining risk levels. ▪ Overall, the risk levels the IDT designated were appropriate for each category for one of the ISPs observed (33%), based on information and data provided by the IDTs. The individuals' IDTs that did not consistently designate appropriate risk levels for each risk	

#	Provision	Assessment of Status	Compliance
		category included Individual #178, and Individual #161. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in two (66%) of the ISPs meetings observed. The individual's IDT that did not have adequate and appropriate clinical discussion among team members included Individual #178. ▪ Team disagreements regarding risk levels were noted in none of the ISP meetings. ▪ Based on all ISP meetings the Monitoring Team observed, the ISP facilitators kept the team focused in all three (100%) of the ISPs meetings. In addition, other positive observations from the Monitoring Team regarding the ISP meetings included: ▪ Individual #178's mother was able to attend the meeting via conference call and was frequently asked her opinion regarding team recommendations. ▪ Individual #178's team had drafted the IRRF prior to the ISP. ▪ Some of the team members for Individual #178 were actively involved in the ISP process and very familiar with the individual. ▪ The direct support professional present at the ISP for Individual #178 was very attentive to the individual throughout the meeting. ▪ The team for Individual #161 discussed the content of the IHCP at the end of each section of the IRRF and made additions, when necessary. ▪ The team discussed the inclusion of individual-specific triggers for Individual #161 from the PNMP in appropriate risk categories to alert staff to a change in status (e.g., respiratory compromise, cardiac disease, weight). ▪ The team discussed the appropriateness of the content in Individual #161's PNMP. ▪ Individual #264's team had some good integrated discussions. For example, in addressing his PBSP, the Behavior Health Services Provider and Speech Language Pathologist developed a plan to collaborate to ensure that the speech program supported the replacement behaviors included in the PBSP. For his goal to participate in a community activity three times a week, the team discussed the need for this to be integrated with communication strategies (e.g., telling him what was happening before, as well as taking a picture of him in the park to use as a visual cue). Similarly, in designing a tooth brushing goal, the team discussed different reinforcers that might be of use. Problematic areas needing focus or improvement included: ▪ During the ISP for Individual #178, the nurse practitioner noted that the individual did not have a diagnosis of GERD, although it had been noted throughout the IRRF. Clearly, this information had not been communicated to the rest of the team members. ▪ The IRRF for Individual #178 did not include some relevant clinical information in order to designate appropriate risk levels. For example, there were no lab values or ranges included in his IRRF risk categories to indicate how his status had improved or worsened over the past year as compared to the previous year. Also, the IRRF indicated things that the	

#	Provision	Assessment of Status	Compliance
		individual was supposed to have, such as 68 ounces of fluids daily, but gave no indication if the individual was actually consuming that amount on a daily basis. ▪ In addition, the IHCP for Individual #178 did not include nursing assessments that would be required by the nursing protocols for health issues, such as constipation and acne. ▪ The discussion of Individual #178's exposure to the community was very limited. ▪ The annual IRRF did not consistently present a baseline and/or provide data to support if the individual had improved over the past year, maintained, or had gotten worse. For example, Individual's 161's Dental risk section did not provide this information. There was no data to indicate her oral hygiene rating from last year to this year. ▪ The IHCP for Individual #161 did not identify the implementation of PNMP compliance monitoring which would include the identification of information to answer the questions of who performs the monitoring, the type of monitoring to be performed (e.g., mealtime, positioning, etc.), how frequently the monitoring is performed, and how the monitoring is analyzed as established by Facility protocols. For example, a tortoise positioner had been recently implemented for Individual #161. The purpose and implementation schedule for the tortoise positioner as well as monitoring (i.e., compliance and effectiveness) should have been integrated in the IHCP. ▪ The team did not adequately discuss current status of supports and/or present data to indicate that Individual #161's status was better or worse over the course of the year. For example, under dental, the IRRF current supports stated: "[Individual #161] has general anesthesia at [community hospital] due to her compliance medical history." The narrative indicated that Individual #161 received suction tooth brushing three times a day by nursing. However, there was no clinical data to report on the effectiveness of suction tooth brushing over the past year. ▪ For Individual #264, the team identified the need for a Dental Department representative to be present at the ISP meeting, but no representative was in attendance. According to the IRRF, Individual #264 "has general anesthesia for exam, DS&RP [deep scaling and root planing], full mouth radiographs, and any restorative work and or [sic] extractions if needed every six months." His behavior was described as "poor." His team, without the benefit of a dental representative, did discuss revising his tooth brushing SAP to incorporate a more meaningful reinforcement. However, despite the restrictive procedures required to complete even basic dental care, the team did not discuss the need for a desensitization plan or other strategies to reduce the need for general anesthesia. ▪ In discussing Individual #264's risk ratings, the team referenced the draft IRRF, which frequently listed relevant clinical data, such as lab values, frequency (or lack thereof) of health issues, etc. However, with regard to the Behavioral Health section, the team did not refer to specific data related to Individual #264's PBSP goals and objectives, or objectives related to his psychiatric plan of care. General statements were made such as: "[Individual #264] has made progress in regard to challenging behaviors, not only during the past year, but over the past 2-4 years. He has some cyclical patterns, but with overall downward trends for SIB aggression, self-stimulation, and pica. He has shown some significant	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>progress in replacement behavior of functional communication…" Although this was a good general summary, it is important for the team to consider actual data over time.
▪ On a related note, Individual #264's team did not discuss, nor did the draft IHCP include measurable goals and objectives to determine whether he was improving, regressing, or remaining stable.

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 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.</td><td></td></tr>
<tr><td>I2</td><td>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.</td><td>Based on a review of the Facility's Self-Assessment, since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement:
▪ The Facility's Self-Assessment indicated that from May through November 2013, a 20% (N=89, n=19) random sample was selected of Change of Status (CoS) ISPAs (i.e., every third hospitalization from the Hospital Visits reports and one individual from the Morning Provider meeting tracking with a change of status not related to a hospitalization) to determine if the IDTs addressed changes of status within five days. Based on these reviews, the Facility reported the following data:
<table>
<tr><th>Month</th><th>Compliance percentage</th><th>Total (N)</th><th>Sample (n)</th></tr>
<tr><td>May 2013</td><td>33%</td><td>19</td><td>3</td></tr>
<tr><td>June 2013</td><td>67%</td><td>10</td><td>3</td></tr>
<tr><td>July 2013</td><td>100%</td><td>18</td><td>3</td></tr>
<tr><td>August 2013</td><td>33%</td><td>12</td><td>3</td></tr>
<tr><td>September 2013</td><td>100%</td><td>10</td><td>3</td></tr>
<tr><td>October 2013</td><td>50%</td><td>13</td><td>2</td></tr>
<tr><td>November 2013</td><td>100%</td><td>7</td><td>2</td></tr>
</table>
▪ Although the Facility noted that there appeared to be improvement in the timeliness and the quality of the documentation of the ISPAs, it was unclear to the Monitoring Team how quality was determined and accounted for in the chart of data above. In addition, it would</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		have made the data clearer if the compliance findings addressing hospitalizations and change of status not related to a hospitalization were presented separately in order to identify any strengths or weaknesses between the two systems. Also, the Self-Assessment indicated that although there was not a consistent issue noted with a particular IDT failing to meet, the Facility reported that there was a pattern regarding recommendations not being accepted for two of the IDTs. However, there was no additional information contained in the Self-Assessment addressing the specific reasons why some recommendations were not accepted and what actions were taken to reconcile the issues. Although this was a positive step forward regarding the monitoring of the interventions/plans generated at the ISPA meetings, no criteria were provided that indicated what constituted "clinically adequate," or if the interventions/plans were actually implemented. Self-rating: 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 consistently acted upon within 5 days and the supports implemented were not consistently found to be clinically adequate. Action Plans for Section I.2 are in place to address the implementation of the assessment process and evaluation of quality of the recommended assessment." Based on a review of records for 23 individuals determined to be at risk (i.e., Individual #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues), 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	

#	Provision	Assessment of Status	Compliance
		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. Nursing Assessments Based on a review of 23 individuals' records for which assessments were to be completed to address the individuals' at-risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues. 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. In fact, the Monitoring Team found considerably less information documented regarding the high-risk health indicators, and in many of the cases reviewed, there was no information contained in the quarterly Comprehensive Nursing Assessment addressing the high and medium health risks. As noted in previous reports, nursing had no specific procedure in place to address 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 for which nursing was responsible. 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. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. Medical Assessments For eight individuals, specific sections of the medical record were reviewed. Five of the eight individuals had had ER visits. Two of the five included the notation that the ER reports were not	

#	Provision	Assessment of Status	Compliance
		available in the record. For the completion of quality open record reviews, IDT discussion and development of COS ISPAs, and IRRF development and revision, the availability of key documents is of fundamental importance. The Facility should ensure such documents are available for the ISPA and IRRF development, and it is recommended that expectations be set for the basic list of documents that are included as part of the review. Monitoring efforts should include components to ensure that necessary information is reviewed. Quality of the integrated health care process will not occur when critical information is not available. The integrated process for addressing individuals' at-risk issues reflected progress with some teams and less progress with others: ▪ For Individual #43, there were two hospitalizations and one ER visit from May 2013 through August 2013. There were significant changes in health status recorded (i.e., dehydration, placement of a PEG tube, and a gastrointestinal bleed). The record reflected several IDT meetings, with ISPA documentation in timely response to a series of changes in health status. On 5/14/13, the individual returned from the ER with a diagnosis of bronchitis causing hypoxia. An ISPA, dated 5/16/13, provided documentation of the discussion and decisions. The Disability Rights of Texas Representative attended, with focus on ensuring there were program opportunities away from the individual's residence. The Representative suggested that allergies were a potential contribution to the hypoxia, but the PCP was present and explained the need to avoid allergy treatment, given the history of chronic lung disease. A 7/16/13 ISPA reviewed an IDT discussion regarding the lack of participation in off-home programs, as well as the observation that going outside exacerbated breathing difficulties and required frequent nebulizer treatments. At that time, the RN Case Manager and PCP correlated the potential of aspiration contributing to the reactive airway disease, and the individual was scheduled for a Modified Barium Swallow Study (MBSS). On 7/24/13, the MBSS was completed, and it was recommended the individual have an order for nothing by mouth (NPO). The PCP then arranged a visit the next day with the gastrointestinal (GI) specialist. A Percutaneous Endoscopic Gastrostomy (PEG) was placed, and the individual was discharged on 7/29/13. An ISPA, dated 7/30/13, recorded the need for 24-hour nursing care, and oxygen administration, with increased treatment required by the new PEG tube. At that time, the individual became part of the PNMT caseload. Treatment for Methicillin-resistant Staphylococcus aureus (MRSA) was ongoing. A subsequent hospitalization included unstable vital signs, a GI bleed of undetermined etiology, and cellulitis at the feeding tube site. Returning on 9/3/13, an ISPA of 9/4/13 outlined seven preventive steps that were to be implemented. A follow-up ISPA, dated 11/14/13, included discussions and recommendations for tube feeding rates and positioning of pillows in his bed to both improve comfort and reduce potential harm as the individual had the ability to self-position. It was not identified if any of the post-hospital ISPAs had been accepted initially or revised prior to acceptance by the provider morning meeting. However, it appeared the team was diligent in reviewing several areas of health and safety. It is important to note that the persistence of reactive	

#	Provision	Assessment of Status	Compliance
		airway disease did not end with the assumption it was due to an environmental issue or was part of ongoing asthma or emphysema, but the nurse and PCP began to look at a list of potential causes. As dysphagia is a common disorder in this population, it was considered important to evaluate. This led to tube placement, followed by a decision of the team to move the individual to a different home where there was more intensive nurse monitoring. The individual was re-hospitalized within three weeks, and this was followed by the team identifying several concerns and steps to be taken as outlined in the ISPA. This was an example of integrated clinical care, which was provided in a timely manner. ▪ In contrast, Individual #283 had an Active Problem List, which included seizure disorder, recurrent aspiration pneumonia, dysphagia, PEG-tube placement in 2008, and gastroesophageal disease (GERD). The individual was hospitalized from 8/14/13 to 8/16/2013 for a fever. The individual subsequently developed diarrhea and was found to be C difficile positive. The ISPA, dated 8/19/13, reviewed the history and findings, but did not review any preventive steps, such as the reason for C difficile. There was also mention of opacities in the chest x-ray, but there was no further discussion. An ISPA, dated 9/19/13, documented a meeting between the PNMT and IDT in preparation for the individual's move back to the home from Quail. There was to be increased training of reflux precautions and monitoring of head of bed elevation. A follow-up ISPA, dated 10/7/13, did not provide any additional preventive steps. The individual was hospitalized from 10/8/13 to 10/11/13, and returned the same day to the hospital for readmission from 10/11/13 to 10/29/13. Originally hospitalized for pneumonia, continued hypoxia resulted in bronchoscopy being completed with multiple mucous plugs found causing atelectasis. Additional preventive steps were providing breathing treatments and increased pulse oximetry readings for one week. There was no discussion concerning preventive steps, such as whether hydration was a concern and whether urine output was to be tracked; whether respiratory therapy was consulted to provide an opinion and other pulmonary toilet options, such as chest percussion or other procedures to decrease atelectasis and mucous plugging; a follow-up pulmonary consult with a discussion of options (the individual did not have a pulmonary diagnosis listed on the Active Problem List other than a history of recurrent aspiration pneumonia); and/or use of mucolytics (i.e., the preventive steps so mucous plugging would not cause hypoxia and hospitalization again). There was no discussion of any other contributing illness that could be treated to maximize health, such as GERD (which was listed on the Active Problem List). If there were potential contributing comorbid conditions, the record did not reflect that these potential diagnoses were evaluated and treated or ruled out as not being present. The individual had a history of GERD, but there was no discussion of whether the head of bed elevation was being followed, or monitored to ensure compliance with orders, whether suction tooth brushing was done correctly (and any increased, ongoing monitoring to ensure staff were doing this appropriately). There were no action steps to determine whether there were any contributing environment	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>concerns such as allergens from housekeeping cleaning agents, etc. For this individual, there appeared to be many unknowns that needed evaluation.

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.</td><td></td></tr>
<tr><td>I3</td><td>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.</td><td>Based on review of the Facility's Self-Assessment, since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement:
▪ The Facility's Self-Assessment indicated that due to the lack of measureable objectives/steps contained in the IHCPs, determining the implementation of those steps was difficult. The ADOP's random review of 10 records found that it was not possible to determine if implementation of the IHCP had occurred within 14 days as required by the Settlement Agreement, which was consistent with the findings of the Monitoring Team for this area as discussed below. Consequently, the Facility indicated that further review of this area was to be discontinued until a process to determine the actual implementation of the IHCPs could be formally established.
▪ A 20% (103=N and 21=n) random sample of IHCPs and ISPs (i.e., the fourth ISP from the monthly ISP schedule for each month from May through October 2013) was reviewed to determine if the IHCPs were developed and integrated into the ISPs addressing the high and medium health risk. Although the data indicated that progress had been made regarding having a current IHCP, the Facility found problematic issues regarding the integration of the IHCP into the ISPs, and the high and medium risks being addressed. Although this was very promising data, it was not clear to the Monitoring Team what the specific criteria consisted of in rating compliance with these items. The Self-Assessment did indicate that all medium and high health risks were not being consistently addressed in the IHCPs, and that in addition, behavioral health goals and steps were also frequently found to be omitted from the IHCPs, which also were consistent trends noted in the findings from the Monitoring Teams' reviews.

<table>
<tr><th>Probe</th><th>May 2013</th><th>June 2013</th><th>July 2013</th><th>August 2013</th><th>September 2013</th><th>October 2013</th><th>Overall Compliance</th></tr>
<tr><td>IHCP Current</td><td>75%</td><td>67%</td><td>67%</td><td>100%</td><td>100%</td><td>75%</td><td>81%</td></tr>
<tr><td>IHCP Integrated</td><td>0%</td><td>33%</td><td>33%</td><td>50%</td><td>33%</td><td>75%</td><td>37%</td></tr>
<tr><td>High and Medium risk addressed</td><td>50%</td><td>67%</td><td>67%</td><td>50%</td><td>50%</td><td>75%</td><td>60%</td></tr>
<tr><td>Total Population (N)</td><td>18</td><td>17</td><td>16</td><td>18</td><td>16</td><td>18</td><td>103</td></tr>
<tr><td>Sample (n)</td><td>4</td><td>3</td><td>3</td><td>4</td><td>3</td><td>4</td><td>21</td></tr>
</table>
▪ From the same sample, the Facility conducted a review to determine if the required components of the IHCP were appropriately addressed. The Facility indicated that</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		problematic issues continued to be found regarding "the basic components of the IHCPs being completed accurately." Although the Facility indicated there was an increase in compliance regarding the development of measurable nursing goals resulting from reference materials provided to the RN Case Managers in August 2013, there was no indication that the quality of the items below were assessed for compliance rather than just the completion of the required documentation. Quality is an important component the Monitoring Team uses in making compliance determinations, and as a result, the Facility's findings were not in alignment with the Monitoring Team's findings, as noted below.	

Probe	May 2013	June 2013	July 2013	August 2013	September 2013	October 2013	Overall Compliance
Goals measurable	25%	33%	0%	50%	67%	50%	38%
Steps measurable	25%	0%	67%	0%	0%	50%	24%
Preventative interventions	25%	0%	67%	0%	67%	75%	39%
Responsible person	75%	67%	67%	100%	100%	100%	75%
Frequency of monitoring	0%	0%	0%	0%	0%	0%	0%
Total Population (N)	18	17	16	18	16	18	103
Sample (n)	4	3	3	4	3	4	21

- In addition, the Facility's Self-Assessment indicated that in January 2013, the QA/QI Council deferred the QA Department's monitoring activities for Section I due to the changes in processes regarding the At-Risk system. After reviewing the areas that Nursing Services and the QIDP Department were currently monitoring, the Facility decided to use a variety of monitoring tools already being completed for other sections of the Settlement Agreement that also addressed risk information, specifically, the Section F and Section M existing monitoring tools. In addition, the Facility indicated that the QA Indicators would be incorporated and reviewed on a quarterly basis as part of the Section I QA/QI presentation. However, the information contained in the Self- Assessment indicated that since the recent implementation of the new Section F tool and the re-implementation of the Section M tools, there was not enough data to analyze at the time of the review.

<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 did not contain the required elements making it impossible to determine if they were implemented within 14 days. Action plans for Section I.3 address implementation, accessibility, and quality of the IHCP."

#	Provision	Assessment of Status	Compliance
		Based on a review of 23 records for individuals determined to be at risk (i.e., Individual #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues), 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%). ▪ Although all 23 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, none (0%) sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate, in none (0%) of the cases reviewed. The 23 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 IHCPs addressing, for example, the need to encourage compliance with a healthy diet and encourage adequate fluids and exercise, 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 23 of the 23 cases (100%). ▪ 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 other 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.	

#	Provision	Assessment of Status	Compliance
		At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this area. This finding 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 1/9/14 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 11/13; 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 medication; ▪ 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 The materials related to the Pre-admission Meeting, on 1/7/14, for an Individual who was scheduled for readmission to the Facility in the near future; 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;" and • 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 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 (CPA); 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 Documentation for the following episodes in which chemical restraint (including the dates of restraint) was administered: Individual #288 (11/8/13 at 12:25 p.m., 11/8/13 at 12:51 p.m., and 10/11/13 at 10:44 a.m.), and Individual #4 (10/3/13 at 8:42 a.m., and 10/5/13 at 1:11 p.m.); o List of individuals who received pre-treatment sedation for medical and/or dental appointments, from 5/13 to 11/30/13; o The utilization data for dental pre-treatment sedation and Intravenous (IV) or general anesthesia, from 5/1/13 to 11/30/13; o Spreadsheet of individuals listing the status of CPA completion as of 11/30/13; o MOSES/DISCUS side effect scales for the following five individuals who were prescribed Reglan: Individual #323, Individual #136, Individual #199, Individual #225, and Individual #62; and o The ISP and Psychiatric Medication Treatment Plan (PMTP) for the following 11

individuals:

INDIVIDUAL #	DATE OF ISP	DATE OF PMTP	STATEMENT IN ISP AFFIRMING PMTP WAS REVIEWED AND APPROVED BY THE IDT
Individual #116	12/19/13	11/20/13	No*
Individual #60	12/18/13	11/20/13	Yes
Individual #174	12/17/13	11/20/13	Yes
Individual #38	12/10/13	11/20/13	Yes
Individual #26	12/9/13	11/20/13	Yes
Individual #155	12/5/13	11/20/13	Yes
Individual #23	11/22/13	11/21/13	Yes
Individual #318	11/21/13	8/22/13	Yes
Individual #45	11/13/13	8/22/13	Yes
Individual #184	11/5/13	8/22/13	Yes
Individual #245	10/30/13	7/17/13	Yes

*The 12/19/13 ISP stated: "Individual #116 does not have a Psychiatric Treatment Plan at this time."

- **Interviews with:**
  - Dr. Richard Weddige, Director of Psychiatry, and Shiraz Vahora, M.D., Staff Psychiatrist, on 1/6/14, 1/7/14, and 1/9/14;
  - James Forbes, Director of Behavioral Health Services, on 1/6/14;
  - Dr. Russell Reddell, Director of Dental Services, on 1/6/14;
  - John Todd, R.Ph., Clinical Pharmacist, on 1/6/14;
  - Dr. Richard Weddige, on 1/6/14, 1/7/14, 1/8/14, and 1/9/14;
  - Christina DeLos Santos, Acting Human Rights Officer, and Robin Seale, Assistant Facility Director for Programs, on 1/8/14;
  - Program Compliance Monitor for Psychiatry, Dr. Richard Weddige, and Shiraz Vahora, M.D., on 1/9/14;
  - Edie McFadden, RN (Psychiatric Nurse), on 1/7/14; and
  - Dr. Richard Weddige, and Edie McFadden, RN, to review Polypharmacy Committee Meetings data, on 1/6/14.
- **Observations of**:
  - Polypharmacy Committee Meeting, on 1/6/14;
  - Morning Provider Meeting, on 1/9/14;
  - Pharmacy and Therapeutics Committee Meeting, on 1/9/14;
  - Psychiatric Clinics at 514 South Cedar (Birch), on 1/7/14;
  - Psychiatry Clinics on 526 North Cedar (Tulip), on 1/8/14;
  - Neurology Clinic with Dr. Daniel Hurst, on 1/8/14;

	o ISP meeting for Individual #178, on 1/7/14; o Human Rights Committee Meeting, on 1/8/14; o Pre-admission Meeting for an individual scheduled to be re-admitted to the Facility in the near future, on 1/6/14; and o During the Neurology Clinic on 1/8/14, and the visits to the residences and day/vocational programs at LBSSLC, the following individuals were observed: Individual #60, Individual #140, Individual #80, Individual #288, Individual #88, Individual #124, Individual #271, Individual #272, Individual #108, Individual #83, Individual #99, Individual #254, Individual #240, Individual #235, Individual #279, Individual #75, Individual #213, Individual #154, Individual #27, Individual #40, Individual #251, Individual #155, Individual #7, and Individual #300.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 11/13/13. 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 the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. On 1/9/14, during the onsite review, these materials, including the Facility Self-Assessment, were reviewed with the Director of Psychiatry, the staff Psychiatrist, 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 Director of Psychiatry, Psychiatric Clerk, Psychiatric Nurse, Staff Psychiatrist, and the QA Department's PCM assigned to work with the Psychiatry Department. 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 from five 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 that would total 20 percent on an annual basis, or five percent on a quarterly basis. Every month, each of the two Facility Psychiatrists reviewed one record related to an individual treated by the other Psychiatrist. These two records were randomly selected by the PCM from the last two months of ISPs. The PCM also reviewed each of these records. An assessment of inter-rater reliability based on these two independent reviews (the PCM's review and that of each Psychiatrist) was performed for both of these reviews each month. This monthly process resulted in 24 reviews per year, or approximately 20 percent of the 123 individuals prescribed psychotropic medication. The data generated was reviewed quarterly in the Facility's QA/QI meeting, and discussed monthly with the Psychiatry Department. In order to become more familiar with the clinical aspects of psychiatric care and to assist in appropriately performing the QA review of an individual's psychiatric record, the PCM 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," finalized by the DADS State Office 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 address the 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. However, the two Psychiatrists did assess whether or not the criteria for the diagnosis were met, and the PCM ensured that the diagnosis was consistent throughout the record. o The monitoring tool included adequate methodologies, which consisted of the review of 24 records per year (20 percent of the individuals prescribed psychotropic medications) by three independent reviewers (two of which were practicing Psychiatrists), 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 percent over a one-year period). These sample sizes were adequate to consider them representative samples. o The audit tool contained limited instructions and guidelines to promote consistency in monitoring and the validity of the results. The auditing tool did not come with detailed instruction or guidelines. As noted above, the PCM 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 PCM 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. It should be noted that the tool did provide direction as to which section of the record would contain the answers to specific questions in the audit tool. o The following professionals were responsible for completing the audit tool: The PCM, the Director of Psychiatry, and the staff Psychiatrist. o The staff responsible for conducting the audits/monitoring appeared clinically/programmatically competent in the relevant area(s). As noted above, the PCM and the Psychiatry Assistant previously performed these reviews. Commencing in August 2013, the two Psychiatrists (each looking at a file of the other) performed the primary reviews, and the PCM was only involved in the secondary inter-rater reliability review.

	○ With regard to inter-rater reliability, the method the Facility used appeared to consist of a simple mathematical comparison of the results of the two different yes/no ratings to ascertain to what degree they were in agreement. These were then reported as simple percentages. Any disparities between the results obtained through the two reviews were actively discussed in the monthly Psychiatry internal QA/QI review, which was attended by the two Psychiatrists and the PCM. ▪ 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 requirements of the Settlement Agreement. The primary examples of this were the Reiss Screen spreadsheet (as discussed with regard to Section J.7), the MOSES/DISCUS completion-tracking spreadsheet (as discussed with regard to Section J.12), the Informed Consent and annual updates spreadsheets (which related to Sections J.10 and J.14), 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 continued to track the attendance of the individuals' Psychiatrist at their annual ISP meetings. In this regard, the Department also tracked the completion rate for the annual Psychoactive Medication treatment Plan, and the date of its submission to the QIDP as part of the pre-ISP process. ▪ In some ways, the Facility consistently presented data in a useful way. However, problems were noted. The following summarizes the positives and negatives: ○ 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. Results on the spreadsheets were reported as completion rates, which were then translated into percentages. ○ Of concern, the reviews primarily focused on the presence or absence of items. 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 no prompt in the tool to ascertain if there had been an adequate description of the symptoms of the disorder. However, as noted above, the two Psychiatrists were now performing the primary review of colleagues' records. ○ The work of the QA Department for Section J was completely integrated into the self-assessment process of the Psychiatry Department. As indicated in the narrative description of the process above, the PCM for Psychiatry worked closely with the staff Psychiatrist 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 the 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.8, J.9, J.10, J.11, J.12, J.13, J.14, and J.15. These findings were generally consistent with those of the Monitoring Team. There was 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. Review of the sample of five administrations of chemical restraint, evaluated in conjunction with Section J, found that there was sufficient information to determine that chemical restraint was not being used for punishment or for the convenience of staff. The Facility had developed a new initiative, which should decrease the need for chemical restraint for individuals with major psychiatric disorders that periodically produce behavior disruptions and may require chemical restraint. It is not clear how this initiative will evolve and, thus, the finding of noncompliance was carried forward. This issue is discussed in more detail below. ▪ 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: Since the Monitoring Team's previous review, the Psychiatry Department at LBSSLC has undergone significant personnel changes. The Psychiatric Assistant, who had been an integral member of the team throughout the time that the Settlement Agreement had been in place, retired shortly after the prior review. The Psychiatry Clerk, who had been instrumental in organizing the data related to the Department's initiative to decrease polypharmacy, left the Facility for another position several weeks before the current review. However, the Department had been able to hire a full-time Psychiatric Nurse, who had assumed many of these responsibilities. The Psychiatric Assistant position remained open. The Facility continued to employ two full-time Psychiatrists who shared the responsibility for providing direct psychiatric services to the 123 individuals prescribed psychoactive medication at LBSSLC. In addition, the Facility contracted with a part-time Consulting Psychiatrist, whose time was primarily devoted to updating the CPAs and performing second-opinion consultations for the two full-time Psychiatrists, on an as needed basis. The Facility's internal data indicated that they continued to update the CPAs on an annual basis for 100 percent of those individuals prescribed psychotropic medication, and the current review of the records of 15 percent of those individuals prescribed psychotropic medication was consistent with this finding. The quality of the content of these documents also remained consistent with the requirements of the Settlement Agreement. The initiative for the Psychiatrists to attend all of the ISPs for the individuals they served also had continued, and internal documentation indicated an attendance rate of 95 percent. The review conducted of the sample of individual records found an attendance rate of 90 percent for a slightly different time period. This review also found that the Psychiatry Department submitted the Psychotropic Medication Treatment Plan (PMTP) to the Interdisciplinary Team (IDT) at least ten days before an

	individual's annual ISP at a rate of 97 percent, as based on an expanded review of 24 percent of the final ISP documentation and related PMTPs. However, as will be discussed in the report that follows, there had been deterioration in the content of both the narrative sections of the ISP and the Integrated Risk Rating Form (IRRF). The progress in reducing and carefully reviewing the number of individuals, who were prescribed psychotropic medications that constituted polypharmacy, also had continued. The rate of active polypharmacy had increased somewhat. This was primarily due to individuals who had been admitted in recent years from the community on polypharmacy, but who had resided at LBSSLC longer than one year, migrating from the New Admission category to the Active category. In addition, changes in the clinical status of some individuals, who had been stable, led to their also being moved to the Active category. One would expect the rates of polypharmacy to fluctuate somewhat over time, but the rates at LBSSLC remained low, and the teams were making active efforts to challenge and reduce polypharmacy, when appropriate.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	A total of 123 individuals at LBSSLC were prescribed psychotropic medication. A sample of individuals was selected for the current review, as described in the section listing the documents reviewed. This included 19 individuals, or 15 percent of those prescribed psychotropic medication. 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 the individuals prescribed psychotropic medication. The Department of Psychiatry maintained data related to its progress in completing the CPAs for those individuals prescribed psychotropic medication. Review of this spreadsheet entitled: "Psychiatric Assessments (Active List)," indicated that an initial or	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		updated CPA had been completed for all (100%) of the 123 individuals who were prescribed psychotropic medication, within the prior twelve months. 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 diagnostic sections of the records provided a thorough description of the symptoms that supported the psychiatric diagnosis. For all (100%) of the 19 individuals, the current review indicated that the psychiatric diagnosis 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 symptoms in the three primary sources where the diagnosis was discussed (i.e., CPAs, Quarterly Reviews, and Psychiatric Consultations) was sufficient to meet the criteria 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 initial reviews had identified a significant problem related to the identification of behaviors that were listed as "targets" of psychotropic medication in the Quarterly Psychiatric Reviews, and then 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 Sections J.8 and J.9. Accordingly, the Facility remained 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 this sample, the individuals had been appropriately diagnosed, and the diagnostic material was found to meet the standards set forth in the Settlement Agreement.	
J3	Commencing within six months of the Effective Date hereof and with	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	Noncompliance

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	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.	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 24 (20%) of the 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 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 Department and Behavioral Health Services, this problem had been eliminated in the clinical documentation of the sample of records of 19 (100%) individuals receiving psychotropic medication. (This is further discussed with regard to Sections J.8 and J.9.) The quality of PBSPs is 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 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:	

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INDIVIDUAL #	DATE	TIME	MEDICATION
Individual #288 (Episode A)	11/8/13	12:25 p.m.	Haldol 5 milligrams (mg)
Individual #288 (Episode B)	11/8/13	12:51 p.m.	Ativan 2mg IM
Individual #288 (Episode C)	10/11/13	10:44 a.m.	Ativan 2mg IM
Individual #4 (Episode A)	10/3/13	8:42 a.m.	Benadryl Haldol 1mg IM
Individual #4 (Episode B)	10/5/13	1:11 p.m.	Haldol 5mg Ativan 2mg IM

The chemical 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 the documentation following the prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. This section of the documentation was completed for all (100%) of the five individuals. However, the documentation for Individual #288 (Episode A) indicated that this individual was aggressive and agitated prior to the restraint, but did not describe the specific antecedent events. Specifically, the information in this section stated: "Individual #288 continued to be aggressive towards staff. Redirections were not successful." The other four records contained more specific information or represented a chemical restraint that followed a prior restraint for which this information was adequate. Thus, the documentation was found to be adequate for four of the five (80%) examples.
- 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 found to be adequate for all of the five (100%) individuals.
- The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for all (100%) of these individuals. However, for all of these individuals, with the exception of Individual #4 (Episode B), the documentation indicated only that the individual refused or was too aggressive to cooperate. For Individual #288 (Episodes A, B, and C) respirations were noted; but for Individual #4 (Episode A), there were only global descriptions of the individual's mental status and the respirations were not recorded. Thus this review found that in four of the five incidents reviewed (80%), there was an attempt to assess the individual's physiological status.

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		▪ The face-to-face post-restraint debriefing was completed for all five (100%) episodes of chemical restraint in the sample. The staff and individual interview (debriefing) sections were completed within 24 hours and contained an adequate description of the antecedents, and an overall summary of the events. ▪ The Chemical Restraint Clinical Review Form was completed for all five (100%) individuals in a timely manner. Each of the five Clinical Review Forms contained comments by the Pharmacist and Psychiatrist related to both the appropriateness and the potential side effects of the pharmacological intervention. These comments appeared at the end of the Chemical Restraint packet and, thus, were preceded by nine to ten pages of the specific and detailed information related to the incident, as described above. Thus, the essential five elements of the documentation needed to verify the appropriate utilization of chemical restraint were adequately completed for these components for four of the five (80%) individuals in this sample. However, the deficits in the initial description of the setting of events by the direct support professional for Individual #288 (Episode A) were compensated for by the review found in the face-to-face debriefing. The detailed description of the events surrounding the episode of chemical restraint contained in the face-to-face debriefing session were found to be useful in providing the context for the restraint in all five (100%) of these episodes. There was an attempt to monitor at a minimum the individuals' respiratory status for those individuals who were too aggressive to monitor all of the physiological parameters for all but one of these individuals (80%) LBSSLC 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. Any deficits found in the initial description of the context for these events were subsequently expanded upon in the face-to-face debriefing. Accordingly, the review of these documents, in addition to the other sources of evidence described above, did not raise concerns that the Facility was utilizing psychotropic medication for punishment, or for the convenience of staff. During the onsite review, the Directors of Psychiatry and Behavioral Health Services	

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		reported that they had developed a new initiative to identify those individuals who periodically required chemical restraint for episodes of behavioral issues that appeared to be directly related to an underlying psychiatric illness, such as Bipolar Disorder. The Facility's longitudinal data indicated that a significant number of episodes of chemical restraint were accounted for by a relatively small number of individuals with recurrent periods of extreme behavior dyscontrol. The two disciplines had jointly identified ten individuals who met these criteria, and were proposing to develop protocols that would enable the treating Psychiatrist to intercede with pharmacological interventions that would reduce, if not eliminate, the need for chemical restraint. It was not clear, at the time of the Monitoring Team's onsite review, exactly how these protocols would be implemented. If these interventions included the implementation of pharmacological strategies that were individually specific and designed to prevent the episodic behaviors that often resulted in the need for chemical restraint, this could represent a positive intervention. However, it would need to be clear that these protocols were not sanctioning the use of chemical restraint on a PRN or "as needed" basis for these individuals, which could then be inconsistently administered in an inappropriate manner. In developing procedures to define the use of such protocols, it is also essential to remember the Settlement Agreement's definition of chemical restraint: "Chemical restraint means any drug that is prescribed or administered to sedate an individual, or temporarily restrict an individual's freedom of movement, for the purpose of managing the individual's behavior." When such drugs are prescribed on a temporary basis, the protections that need to be in place for "chemical restraint" need to be in place no matter what the Facility decides to rename it. The finding of noncompliance was continued from the Monitoring Team's prior review, as it was not yet apparent how this new initiative would evolve.	
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	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." The current version of this document was not dated, but the Facility indicated that this information was updated weekly, and the document was scanned on 1/9/14. The column that included individuals with a notation describing a Rights Restriction for "Dental Sedation" listed 113 unique individual names. The column entitled "Medical Sedation" listed 18 unique individual names, as compared to 23 at the Monitoring Team's last review, and 41 at the review prior to that. Seventeen individuals were listed as requiring pre-treatment sedation for medical procedures, as well as for dental procedures. Thus, only one individual had consent for medical sedation and not also for dental. The right-hand column of this spreadsheet indicated whether there was a specific	Noncompliance

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	services, and shall be monitored and assessed, including for side effects.	consent for "General Anesthesia" or "IV Anesthesia." This column contained comments related to 102 individuals, which indicated that Consent for IV or General Anesthesia was in place. Of these 102 individuals, there was a further notation that these procedures would be done at the "UMC" (i.e., University Medical Center) or "In the Hospital" for 25 of these individuals The Director of Dental Services indicated that many individuals 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 did not distinguish between these categories. 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 information presented in response to this request was entitled, "Medical/Dental Pre-Sedation. May 2013 – October 2013." The document listed 15 individual administrations of medication for medical procedures, as compared to 16 in the six months prior to the Monitoring Team's last review. The most frequently utilized agent was Ativan, prescribed at a dosage of two milligrams given either by mouth (PO), or IM. At the time of the prior review, Zyprexa or Zydis (Zydis is the rapidly dissolving sublingual form of Zyprexa), 10mgs PO or IM was the second most commonly used medication. It was not used during the current time period. The only agents currently used other than Ativan were as follows: Mellaril 50mg (g-tube times one), Buspar 20mg PO (times one), and Lorazepam 2mg PO (times one). 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. This document indicated there had been zero administrations of pre-treatment sedation for dental procedures in the prior six months, as compared to one such administration in the six months prior to the Monitoring Team's last review. The information from this table, which reported the data on the use of both pre-treatment sedation and "utilized anesthesia," is reproduced below:	

Month in 2013	Total Appointments	Utilized Anesthesia	% Utilized Anesthesia	Utilized Pre-Treatment Sedation	% Utilized Pre-Treatment Sedation
May	68	10	14.71%	0	0.00%
June	34	11	32.35%	0	0.00%
July	32	13	40.63%	0	0.00%

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August	36	18	50.00%	0	0.00%
September	55	9	16.36%	0	0.00%
October	51	10	19.61%	0	0.00%
November	24	12	50.00%	0	0.00%
Totals	**300**	**83**	**27.67%**	**0**	**0.00%**

At the time of the 7/11/13 meeting of the Desensitization Committee, which occurred during the Monitoring Team's prior review, it was reported that there were 115 active Desensitization Plans for dental procedures and 24 such plans for medical procedures. However, the extensive discussion that occurred during that meeting indicated that the Facility was revising the criteria regarding which individuals would require a Desensitization Plan. This was initially being carried out in conjunction with the DADS State Office. It was anticipated that this would lead to a significant reduction in the number of plans required. The scope of the potential revisions discussed in the 7/11/13 meeting was so extensive that the Facility was essentially developing a new approach to the issues discussed in this provision. This would require significant revisions to the processes that had been developed over the prior three years. At that point in time, it also was not clear whether or not those revisions would be consistent with the requirements of this section of the Settlement Agreement. The changes the Facility was proposing would essentially change the criteria for which individuals required a Desensitization Treatment Plan or other strategies to reduce the need for pre-treatment sedation in a manner that had not yet been fully defined. The following paragraph, from the Presentation Book assembled for the Monitoring Team's present review related to Section J.4 summarized the current status of this initiative:

- *Desensitization Committee Meeting has been discontinued due to the changes in the process according to the State Dental Services Coordinator.*
- *Spreadsheet for Individuals Receiving Pre-Treatment Sedation 2013 (May to November).*
- *No Desensitization Summary from the State Dental Services Coordinator resulting from the new process.*

Following the 1/9/14 P&T Committee Meeting, the Medical Director and the Directors of Psychiatry, Behavioral Health Services, and Dental Services, as well as the staff Psychiatrist and other representatives from the Facility, met with several members of the Monitoring Team to discuss the current status of the use of medical and dental pre-treatment sedation. This meeting indicated that the initiative to develop Pre-treatment Desensitization Plans was essentially on hold due to concerns about issues related to the continued administration of pre-treatment sedation. As the Monitor and members of the Monitoring Team discussed with Facility staff, the intent of the Settlement Agreement is

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		to reduce to the extent possible the need for pre-treatment sedation, including oral pre-treatment sedation and the more restrictive practices of IV sedation or general anesthesia. Although there is utility in defining for which procedures the general public routinely requires sedation, this needs to be done carefully. In addition, an individualized approach should be used in determining which individuals would potentially benefit from desensitization plans or other strategies to reduce the need for pre-treatment sedation. Accordingly, the finding of noncompliance was continued, because at the time of the Monitoring Team's onsite review, the initiative to develop pre-treatment sedation plans was effectively on hold until these issues were resolved.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	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 the sample of 19 individuals prescribed psychotropic medication identified a complete, annual updated CPA for all 19 (100%) individuals that met the content requirements specified in the Settlement Agreement, and had been completed within the last year. 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. This was positive, because it maintained this important historical information in an easily accessible format. The spreadsheet the Facility maintained, to track the status of the completion rate of the CPAs, indicated that all 123 of the individuals receiving psychotropic medication had a CPA or CPA-update performed in the last year. The spreadsheet indicated there were no individuals for whom an updated, annual CPA was overdue. Accordingly, LBSSLC remained in substantial compliance with this provision, based on the representative sample of records reviewed during the Monitoring Team's current review that showed the content of the CPAs continued to meet the requirements for quality, and the consistency from the Monitoring Team's prior review findings. In	Substantial Compliance

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		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. The Facility's internal reviews showed similar findings.	
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 prescribed 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. As noted above, LBSSLC elected to utilize the commercially available computer screening to exclude the possibility of inaccurate individual scoring by the Behavioral Health Services Provider. 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 prescribed psychotropic medication effectively assessed for any changes in status that might have occurred in the months prior to the administration of the Reiss. All of those individuals prescribed psychotropic medication had been evaluated with a CPA, and all of the individuals admitted to the Facility in the prior six months were prescribed psychotropic medication at the time of admission and, thus, were evaluated with a CPA. Those individuals also continued to be followed in the Psychiatry Clinics. The Psychiatry Department indicated they also included an evaluation with the Reiss	Substantial Compliance

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		Screening instrument for individuals for whom they were asked to perform a Psychiatric Consultation, as they had done in the past. The results of those Consultations, and the results of the Reiss Screenings were discussed in the Monitoring Team's prior report. During the current onsite review, the Directors of the Psychiatry Department and Behavioral Health Services indicated that the Facility had elected to routinely use the Reiss Screening instrument to screen all individuals not prescribed psychotropic medication every two years. Accordingly, the entire population of individuals who were not prescribed psychotropic medication would be evaluated with this instrument in July 2014, which would be two years after the July 2012 screenings. Administration of the Reiss Screening was required for individuals admitted from the community who were not prescribed psychotropic medication. The Facility's data identified three individuals who had been admitted between 5/15/13 and 11/30/13. All three individuals were receiving psychotropic medication at the time of admission and, thus, had been evaluated with a CPA. The spreadsheet the Facility maintained, to track the administration of the Reiss Screen, indicated that it had been administered to the following three individuals in 2013: Individual #269 (6/6/13), Individual #132 (11/4/13), and Individual #71 (10/7/13). As noted above, these were individuals for whom changes in status had been identified that had the potential to impact their psychiatric health. The only one of these three individuals that received a score above the clinical cut-off score of "nine," was Individual #132. That Reiss Screening had been performed as part of a Psychiatric Consultation related to concerns about the individual's possible depression, as expressed by members of the individual's IDT. The CPA related to this referral was performed by the Director of Psychiatry on 11/16/13, which met the criteria specified in the Settlement Agreement, and included a paragraph in which the results of the Reiss Screening were reviewed. As a result of this Consultation, Individual #132 was prescribed an antidepressant, and was then to be followed by the Psychiatry Department. The finding of substantial compliance was continued from the previous review, because there was evidence that the IDTs were alert to changes in an individual's status and utilized the Reiss Screen in those situations. There was appropriate follow-up for those who had elevated scores. In addition, the entire population of individuals at LBSSLC, who were not prescribed psychotropic medication, was scheduled to receive the Reiss Screening in the coming months, as part of the Facility's policy to administer this instrument every two years.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three	The integration between Psychiatry and Behavioral Health Services was apparent in the interviews with the two Psychiatrists, as well as the interview with the Director of Behavioral Health Services. These interactions also were observed during the	Substantial Compliance

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	years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Psychiatric Clinics conducted by both Psychiatrists, where it was apparent that the Behavioral Health Services Provider had a central role in both the conduct of the meeting, as well as 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 a review of 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 1/7/14 and 1/8/14 were similar to those that had been observed during the Monitoring Team's previous onsite reviews. In general, the duration of each individual multi-disciplinary review was approximately 30 minutes or longer. However, there was no sense of time pressure, nor did there appear to be a limit on the length of time that could be allocated for each review. Thus, the observations of the Psychiatric Clinics and the related documents illustrated the active collaboration between the two disciplines of Behavioral Health Services 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 Behavioral Health Services, 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 primary disciplines that attended the Psychiatric Clinics were Nursing, Psychiatry, Psychology, direct support professionals, and the QIDP. Disciplines such as Speech Therapy, Occupational Therapy, and Physical Therapy were, of course, not able to attend the Psychiatric Clinics, due to additional constraints on their time allocation. However, these disciplines often did attend the individual ISP meetings. At the time of the prior review, the Psychiatrists had begun to attend these meetings. The recent data the Psychiatry Department compiled indicated that, for the time period of May through October 2013, a Psychiatrist attended the ISP meeting for 58 of 61 (95%) individuals receiving psychiatric services.	

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		As indicated in the Monitoring Team's prior review, the Psychiatry Department had developed the PMTP to provide the elements of their Treatment Plan that were both necessary for an adequate review of the Plan by the full ISP Team, and were also responsive to the requirements of Sections J.8, J.9, and J.10 of the Settlement Agreement. The PMTP was initially developed when the Psychiatry Department assumed the responsibility for obtaining the consents for the psychotropic medications from Behavioral Health Services. It subsequently was expanded and utilized for the purposes of providing this information to the IDT as part of the ISP preparation process. The Psychiatry Department was not allowed to prepare information that would then be included in the ISP documentation verbatim. Accordingly, they had attempted to provide the necessary information in the PMTP. The PMTP included a statement that directed the ISP Team to the most recent CPA, which also covered the relevant information in more detail. The rationale that led to the decision not to include the actual PMTP in the ISP, but rather to reference it in the ISP, was described in the following excerpt from Section J.9 of the Monitoring Team's previous LBSSLC report: *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 that is 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 of 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 to what might be an untenable length that in the end could be non-productive while also keeping the responsibility for the content of this material within the hands of the Psychiatry Department.* As noted above, the Facility data indicated that the Psychiatrists had begun to regularly attend the ISP meetings for the individuals for whom they were responsible. Data that would indicate the exact duration of the ISPs, and the length of time that the Psychiatrists were present, could not be identified. However, direct observation by members of the Monitoring Team of the annual ISPs that occurred during the onsite reviews indicated that the usual duration was in the range of three hours. The Psychiatrists indicated they had been directed to be present throughout the entire ISP meeting, and those meetings	

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the Monitoring Team observed during the current and prior onsite reviews confirmed this. In order to confirm that the PMTP was completed in a timely manner, and then transmitted to the IDT at least ten days prior to the actual ISP meeting, the relevant documents were reviewed for the original sample of 19 (15%) individual records of individuals prescribed psychotropic medication. The following data provides the information related to these items for those 19 individuals. The first ten individuals listed in this chart represent those the Facility pre-selected, while the next nine, the Monitoring Team selected on site:

INDIVIDUAL #	DATE OF ISP MEETING	DATE PMTP COMPLETED AND SENT TO IDT	STATEMENT IN FINAL ISP AFFIRMING THAT THE PMTP WAS REVIEWED BY THE IDT AND APPROVED	DOCUMENTATION ON SIGNATURE SHEET FROM THE ISP THAT THE PSYCHIATRIST WAS PRESENT
Individual #84	2/8/13	1/22/13	Yes	Yes
Individual #274	9/25/13	7/12/13	Yes	Yes*
Individual #254	5/6/13	4/2/13	Yes	Yes
Individual #75	10/24/13	7/17/13	Yes	Yes**
Individual #299	2/13/13	1/23/13	Yes	No
Individual #82	2/26/13	1/23/13	Yes	Yes
Individual #10	5/20/13	4/3/13	Yes	Yes
Individual #271	11/7/13	8/22/13	Yes	Yes
Individual #79	6/20/13	4/8/13	Yes	Yes
Individual #310	1/23/13	12/5/12	Yes	Yes
Individual #34	3/15/13	2/5/13	Yes	Yes
Individual #165	11/18/13	8/22/13	Yes	Yes
Individual #315	10/4/13	7/6/13	Yes	Yes
Individual #146	4/12/13	3/6/13	Yes	Yes
Individual #20	10/17/13	7/17/13	Yes	Yes

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Individual #99	12/12/13	11/20/13	Yes	Yes
Individual #288	8/26/13	7/31/13	Yes	Yes
Individual #220	3/18/13	2/6/13	Yes	No
Individual #242	4/24/13	1/7/13	Yes	Yes

**The Attendance Sheet for the 9/25/13 ISP meeting for Individual #274 did not indicate that the Psychiatrist had attended the meeting. However, there was an ISP Addendum on 9/27/13, which was directly related to the Individual's SIB, and the Attendance Sheet for that meeting indicated that the Psychiatrist was present.*
***The Attendance Sheet for the 10/24/13 ISP regarding Individual #75 was blank, and contained no signatures. However, there was a signature sheet dated 11/1/13 that contained the signatures of the individuals who attended the meeting, including that of the Psychiatrist.*

Given the importance of this documentation to provisions J.8, J.9, and J.10, an additional sample of the ISP documentation and the PMTP provided to the IDT prior to the ISP was requested. In order to simplify this request, the Attendance Sheet was not requested, because this allowed the material to be reproduced electronically without copying from the original record. The request was for only a recent sample of the ISPs and corresponding PMTPs for 11 individuals whose meetings the individual's Psychiatrist had attended. Accordingly, the presence of the Psychiatrists was not independently assessed for this sample, because that was one of the selection factors for this group of 11 individuals. The results of this analysis are as follows:

INDIVIDUAL #	DATE OF ISP MEETING	DATE OF PMTP	STATEMENT IN ISP AFFIRMING THAT THE PMTP WAS REVIEWED AND APPROVED BY THE IDT
Individual #116	12/19/13	11/20/13	No*
Individual #60	12/18/13	11/20/13	Yes
Individual #174	12/17/13	11/20/13	Yes
Individual #38	12/10/13	11/20/13	Yes
Individual #26	12/9/13	11/20/13	Yes
Individual #155	12/5/13	11/20/13	Yes
Individual #23	11/22/13	11/21/13	Yes
Individual #318	11/21/13	8/22/13	Yes

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Individual #45	11/13/13	8/22/13	Yes
Individual #184	11/5/13	8/22/13	Yes
Individual #245	10/30/13	7/17/13	Yes

**The 12/19/13 ISP stated, "Individual #116 does not have a Psychiatric Treatment Plan at this time."*

The Monitoring Team discussed the observation that multiple PMTPs had been completed on the same two days (i.e., 11/20/13 and 8/22/13) with the Director of Psychiatric Services. He indicated that the information for the different sections of these documents was compiled by the Psychiatrists over the prior days and provided to the Psychiatry Clerk, who assimilated this information onto the forms and transcribed the final documents on those days.

The following is an example of the statements found in the expanded sample of 30 ISPs, affirming that the material had been reviewed and approved by the IDT. It is from the final ISP from the 4/12/13 ISP meeting for Individual #146:

> *Review and Approval of Psychiatric Treatment Plan:*
>
> *The IDT reviewed, updated, and approved the Psychiatric Treatment Plan, 03/06/2013 to ensure that all appropriate services and supports were included in the plan. [Individual #146's] targeted behaviors are sleeplessness, aggression and food foraging. According to the psychiatrist, [Individual #146's] aggression outweighs the risk of Zyprexa least intrusive medication. Psychiatrist stated that there would be future plans to taper current medication if [the individual] is able to so [sic] improvement. Psychiatry will monitor quarterly for side effects of current medications.*

There were additional comments related to the individual's status in the narrative section of the ISP and the IRRF.

The results of the review of the above referenced objective data was as follows:

- There was evidence that the Psychiatrist attended 17 of the 19 (89%) ISPs included in the original sample of 15 percent of individuals prescribed psychotropic medication;
- The PMTP was completed and available to the IDT for the ISP Preparation process at least ten days in advance of the ISP meeting for 29 of the 30 (97%) individuals in the expanded sample of 24 percent of individuals prescribed psychotropic medication. The individual for whom this criteria was not met was that of Individual #23; and

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		▪ There was an affirmative statement in 29 of the 30 (97%) ISPs in the expanded sample that the IDT had reviewed and approved the PMTP as part of the ISP process. The individual for whom this criterion was not met was that of Individual #116. On 1/8/14, members of the Monitoring Team attended the ISP meeting of Individual #178, 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 prior review, the data the Psychiatry Department maintained indicated that, during the timeframe of October 2012 through May 2013, a member of the Psychiatry Team had been able to attend the ISP meeting for 85 of the 94 (90%) individuals prescribed psychotropic medication and also had an ISP in this timeframe. The record review at that time found adequate discussion of the psychiatric aspects in 17 of 19 (89%) records. The process that had contributed to this improvement included the completion of the PMTP. At the time of the Monitoring Team's prior review, this document contained the following sub-headings, which described the material contained in that section. The relatively minor changes or additions to this document as it currently exists are contained in parentheses: ▪ Demographic Information; ▪ Psychiatric Diagnosis; ▪ Symptoms of Diagnosis; ▪ Target Symptoms Monitored; ▪ Derivation of Symptoms, (a newly added section that indicated discussion of the behavioral and psychological factors that contribute to the behavior); ▪ Psychological Assessment; ▪ Combined Behavioral Health Review/Formulation, which contained sub-headings for Biological, Psychological, and Functional Derivation of Behavior (This material was now covered in the new Derivation of Symptoms); ▪ 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-	

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		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 expanded sample of 24 percent of the individuals prescribed psychotropic medication. It was noted at the beginning of each plan that additional information could be found in the individual's most recent annual CPA. The date the CPA had been prepared also was referenced to facilitate the IDT's recognition of that document. Previously, in addition to the PMTP, the Psychiatry Department, working in conjunction with Behavioral Health Services, made contributions to the Behavioral Health section of the IRRF as part of the ISP preparation packet. This no longer occurred, and it appeared that this decision had been made at an administrative level, above that of the Psychiatry Department. The topics and subheadings of the "Behavioral Health" section of the IRRF, which were found to be adequate during the Monitoring Team's prior review, 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	

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		RISK RATING (INCLUDING RATIONALE FOR RATING): The current review found that this format was no longer being utilized, and, as indicated above, it was not clear why these changes had been made. In the current review, a great deal of variation was found in the IRRF, as well as the narrative sections of the current ISPs. The range of this diversity made it impossible to objectively score these sections of the ISP in a consistent manner. A request for any recent guidance that the Facility might have received related to the completion of the Behavioral Health Services section of the IRRF produced a blank template, which was identified as "SSLC 006B 05/01/2013." The Behavioral Health Services section of this document contained the following outline: ***BEHAVIORAL HEALTH*** ***HISTORY*** *(including historical data if applicable):* *Psychiatry:* • *Demographics:* • *Diagnosis:* • *Current psychotropic medications: Name, dose, frequency, indication, route of administration, change in medication in the last 6 months, due to increased symptoms:* • *Restraints: More than 3 restraints during any 30 day period over the past 6 months: ___ Yes ___ No* • *Chemical Restraints for a behavioral crisis within the past 6 months: ___ Yes ___ No* • *Hospitalizations for a psychiatric diagnosis within the past 6 months: ___ Yes ___ No* *Behavioral Health:* • *Was there a PBSP this year? If yes, list target and replacement behavior for the year; list any changes in interventions this year; list any increase in levels of restrictiveness.* • *Was there a Psychiatric Support Plan this year? List the psychiatric behavior indicators and any changes in the plan over the year.* • *Was there a counseling plan? What was the objective? List any changes this year.* • *Was there a crisis intervention restraint plan or protective mechanical restraint plan this year to instruct staff on the application of restraint? List any changes.* • *Were there any supports, strategies, or treatments from Behavioral Health to reduce restraints? If yes, list these supports, strategies, or treatments.*	

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		CURRENT SUPPORTS *<u>Psychiatry</u>:* • *Review of status and psychiatric symptom data during follow up and Quarterly visits; 2) PBSP, 3) Structured daily activities, Environmental and programming supports; 4) Clinical staff supports; 5) Other (e.g., Counseling):* *<u>Behavioral Health</u>:* • *List the services the Behavioral Health Department is providing to the individual at the present time.* ***CURRENT STATUS** (including effectiveness of program/supports and current data)* *<u>Psychiatry</u>:* • *Psychiatric symptoms: ___ Stable ___Unstable* • *Response to Treatment and Supports: ___ Adequate ___ Inadequate* • *Factors that may cause decompensation (medical, environmental, etc.):* *<u>Behavioral Health</u>:* • *Describe the efficacy of current services from the Behavioral Health Department, including:* *Are the clinical indicators for the current supports showing progress? ___ Yes ___ No* *Are there any trends? ___ Yes ___ No* *Are these in the desired direction? ___ Yes ___ No* • *If a data display would help explain efficacy, please include.* • *If restraints were needed for crisis intervention or protective mechanical restraints, please report on patterns or trend; are the supports, strategies, or treatments from the Department to reduce the circumstances that lead to restraint having an effect on reducing restraints?* ***PROPOSED RECOMMENDATIONS/RATIONALE** (including antecedents, triggers, etc.):* *<u>Psychiatry</u>:* • *Medications: ___ Continue unchanged ___ Proposed Change:* • *Other Supports: ___ PBSP ___ Programming/Activities as determined by the IDT during ISP meeting ___ Others:* *<u>Behavioral Health</u>:* • *List the least intrusive and most positive interventions to respond to the current behavioral health needs.*	

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		• *If restraint is to be considered or recommended due to behavioral crisis or protection due to self-injurious behavior: briefly list recommendations for type of restraint, duration of restraint, purpose, and alternatives to reduce the circumstances that lead to restraint.* ***TEAM DELIBERATIONS AND FINAL RECOMMENDATIONS/CASE FORMULATION*** *Based on the team's deliberation of the psychiatric and psychological information, case formulation, and proposed recommendations listed above, the team determines:* ***Consideration of the Use of Restraint*** *The IDT, with the involvement of the physician, discussed considerations for the use of restraint and recommended: (Choose one of the following)* *a) Based on the IDT's knowledge of this individual there are no known physical, medical or psychological/emotional factors that constitute a risk to the use of restraint.* *b) Based on condition(s) identified, the IDT should consider the risk/benefit in determining if restraint should be used, and put into place any safeguards to minimize the risks as applicable. List the safeguards, identify and justify any specific adjustments to one-to-one supervision while in protective mechanical restraint for SIB.* *Other specific recommendations/plans/information related to restraint:* ***RISK RATING** (including rationale for rating)* The current review indicated that the efforts of the Psychiatry Department to attend the annual ISP meetings on a regular basis had been successfully implemented. The material contained in the CPAs, the documentation in the Behavioral Health and Psychiatric sections of the records identified above, as well as the information contained in the PMTPs, clearly indicated there was integration of psychiatric and behavioral services at LBSSLC. The observation that the PMTP was uniformly made available to the IDT (at least ten days prior to the ISP meeting) at a rate of 97 percent, coupled with a statement that affirmed that the IDT both reviewed and approved the information contained in the PMTP for 97 percent of the individuals in the expanded sample of 24 percent of the ISPs of those individuals prescribed psychotropic medication could be perceived as meeting the requirements for this provision. For that reason the finding of substantial compliance is continued from the prior review. However, the significant deterioration in the quality of the material in the IRRF, as well as the narrative section of the ISPs, is worrisome.	

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		It is clear from the material reviewed at the time of the Monitoring Team's prior review that the Psychiatry Department, working in conjunction with Behavioral Health Services, had been able to formulate this information in an acceptable manner. Accordingly, although the finding of substantial compliance is continued at this time, it will likely not be continued in future reviews, unless the Facility, working in conjunction with the DADS State Office, is able to resolve any issues that might have contributed to the removal of the information present at the time of the prior review, and which is essential to meeting the requirements of Sections J.8 and J.9 of the Settlement Agreement on an ongoing basis. It does not appear that the template dated 5/1/13 would meet these requirements, if filled out as a simple checklist. However, if the different items were viewed as prompts for further discussion, it could be an effective guide. Specifically, these sections should contain information relative to the IDT members' discussion of: 1) the rationale for determining that the proposed psychiatric treatments represent the least intrusive and most positive interventions; 2) a further discussion by the team regarding the integration of behavioral and psychiatric approaches; 3) the signs and symptoms that are monitored to ensure that the interventions are effective; and 4) the incorporation of data into the discussion that would support the conclusions of these discussions.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment,	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as in portions of the documentation found in the sample of 19 records of individuals 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 target behaviors of the prescribed psychotropic medication. The Monitoring Team's initial 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 Psychiatry Department Treatment Plans and the corresponding Behavioral Health Services Treatment Plans were developed through parallel processes that were not fully integrated. Review of the sample of records of 19 individuals prescribed psychotropic medication	Substantial Compliance

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	interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	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 Behavioral Health 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 Behavioral Health 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 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 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 detailed discussion of this topic in the sub-heading "Bio-Psycho-Social-Spiritual Formulation." The completed "Psychiatric Consultation – Diagnostic and Treatment Analysis" was found in each of the 19 individual records reviewed. As noted in relation to Section J.6, 100 percent of these records contained an updated annual CPA that had been performed in the prior year and contained a "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	

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		to address the individuals' target behaviors. As indicated in the discussion of Section J.8, the ISP documentation had been improved through the utilization of the PMTP, which was submitted to the QIDP as part of the pre-ISP planning process, and was then referenced in the ISP. During the Monitoring Team's prior onsite review, members of the Psychiatry Department indicated that the staff that prepared the final ISP documentation could not accommodate the inclusion of the detailed documentation that is 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 QIDP staff, who prepared the final ISP documentation. Accordingly, the Department had developed the PMPT, the contents of which are detailed with regard to Section J.8. This document also referenced the current annual CPA, which contained additional detailed information. This was seen as a reasonable compromise to extending the length of the ISP to what might be an untenable length, which in the end could be non-productive, while also keeping the responsibility for the content of this material within the hands of the Psychiatry Department. The documents referenced in the ISP were designed to address the specific requirements of this provision, as per the recommendations contained in the Monitoring Team's previous reports, related to this provision. 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 being utilized. The PMTP also included a section that discussed the Psychiatrist's thoughts on the question of future community placement, based on the impact of their psychiatric disorder, as well as their clinical stability. The Psychiatrists currently were attending the ISP meetings for the individuals they followed, at a rate of 89 percent or greater. The extensive data reviewed with regard to Section J.8 is also relevant to this Section, as there was a great deal of overlap between Sections J.8 and J.9. Accordingly, the relevant information will only be summarized here. The discussion with regard to Section J.8 indicated that in the review of the sample of 19 individual records, 17 of the 19 (89%) individuals' records indicated 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. In addition, the Psychiatry Department's internal tracking system indicated that during the May to October 2013 timeframe, a Psychiatrist had attended 58 of the 61 (95%) 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. As discussed with regard to Section J.8, an expanded sample of 30 individual records was reviewed in order to assess	

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		the frequency with which the PMTP was provided to the IDT at least ten days before the ISP meeting. The review of the entire sample of 30 individuals indicated that the PMTP had been completed in a timely manner for 29 of the 30 (97%) individuals, and the final ISP documentation contained a declarative statement affirming that the IDT had reviewed and approved the PMTP for 29 of the 30 (97%) individuals. As discussed with regard to Section J.8, although the documentation related to the discussion of this material in the PMTP was impressive, there had been a significant deterioration in the consistency of the complimentary information in the IRRF and narrative sections of the ISP. The extensive discussion of this issue with regard to Section J.8 is also relevant to this Section. As with Section J.8, the finding of substantial compliance was continued from the prior review, due to the extent of the documentation described above and in Section J.8. However, it will be necessary to restore the corollary information in the IRRF and narrative section of the ISP to the quality observed in the Monitoring Team's prior review in order for the finding of substantial compliance to be continued in future reviews.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The 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 added in the Bio-Psycho-Social-Spiritual subsection of the CPA, as well as the "Psychiatric Consultation – Diagnostic and Treatment Analysis," which contained a specific sub-section on "Risk vs. Benefit." In addition, 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 the comprehensive information needed to provide an overview of this aspect of the individual's Treatment Plan for their annual ISP meeting. 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 subsections of this document are described with regard to Section J.8. This information, which was formulated by the Psychiatrist, working in conjunction with the Behavioral Health Services Provider and the members of the IDT that attended the Psychiatric Clinics, also discussed both the	Substantial Compliance

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		realized and potential side effects of the medication, and then weighed them against the potential or realized harm related to the individual's psychiatric diagnosis. These reviews were completed for each different 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 already was 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, and the detailed Polypharmacy Committee Meeting Notes for those individuals whose medical regimens met the criteria for polypharmacy. 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 either biological determined factors, behavioral sources, or a combination of both. The PMTP contained a discussion regarding the role behavioral strategies, which would be considered to be less intrusive than pharmacological approaches. 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. On 1/8/14, a member of the Monitoring Team interviewed the acting HRC Officer and the Assistant Director of Programs. The HRC Meeting also was observed on that day. The reviews the Committee conducted during the meetings the Monitoring Team observed during previous onsite 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 Facility's staff described above, as well as the review of the minutes from prior meetings, indicated that these observations continued to be accurate. Based on the presence and quality of the risk-versus-benefit discussions and the quality of the HRC reviews, the Facility was determined to be in substantial compliance with this provision of the Settlement Agreement.	
J11	Commencing within six months of the Effective Date hereof and with	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	Substantial Compliance

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	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.	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 included 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 ten since that time, with the current frequency of ten. The corresponding data for the individuals prescribed three psychotropic medications indicated a decline from 44 in June 2005, when DOJ's involvement began, to 15 in February 2011, and had ranged from 15 to 18 at the time of Monitoring Team's subsequent reviews. The number at the time of the current review was 14. ▪ The data also substantiated improvement with regard to intra-class polypharmacy. The most significant decline with regard to intra-class polypharmacy was the use of two mood stabilizers, which had decreased from 20 in June 2005, to two in the September 2010 and February 2011 reviews. The frequency has ranged from three to four since that time, with a current frequency of four. ▪ The number of individuals receiving two antidepressants also had gradually declined from six in June 2005, to zero in September 2010. The frequency had been maintained at one for the prior five reviews, and was zero at the time of the current review. The review of the documentation from the "Monthly Facility Review of Psychoactive Medication Polypharmacy Meetings" from July 2013 to January 2014 indicated that a review of each of the individuals prescribed polypharmacy with psychotropic medications occurred each month. The professional staff who routinely attended these meetings was as follows: the Medical Director, Clinical Pharmacist, Director of Psychiatry, Program Compliance Monitor for Psychiatry, Psychiatry Staff, and the Staff Psychiatrist. In October 2013, the new Psychiatric Nurse began attending meetings. On 1/6/14, 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. Beginning in October 2013, the Committee also had instituted a comprehensive review of two	

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		individuals per month. The format of the meeting was similar to that observed during the Monitoring Team's prior onsite reviews. The primary focus of these case-centered reviews related to the continued efforts to decrease the individuals' medications, as well as to 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, progress was reviewed in relation to simplifying these complicated medication regimens. For example, an individual admitted to the Facility in September 2013 was receiving five psychotropic medications at that time, and was receiving only three at the time of the Monitoring Team's most recent onsite review. During the Monitoring Team's initial 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 terminology contained in this provision of the Settlement Agreement clearly indicated that 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, 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 1/6/14 Polypharmacy Committee Meeting, the data presented was organized according to these three categories. Detailed information was presented for each	

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		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 17 (14%) individuals of the total 123 individuals receiving psychotropic medications. However, it should be noted that five of these 17 (29%) individuals were receiving only three psychotropic medications; and an additional three were receiving two psychotropic medications, but both were anti-psychotic agents and, thus, represented intra-class polypharmacy. The increase from nine individuals at the time of the last review to 17 in the Active polypharmacy category was accounted for by the following two factors: a) four individuals migrated from the New Admission category, as they had been at the Facility for one year; and b) four were added due to a change in their psychiatric acuity, which necessitated the prescription of additional medication. ▪ As of the 1/6/14 meeting, there was one individual in the New Admission category who was receiving five medications at the time of admission, which had been reduced to three. ▪ 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 13 (11%) individuals the Facility believed met these criteria. Accordingly, a member of the Monitoring Team performed a detailed review of the evidence that was presented for these 13 individuals. Based on this review, the type of detailed, historical, empirical data required to substantiate clinical efficacy was present for all (100%) of these 13 individuals. The histories contained medication-specific information. This made it possible to ascertain the degree of positive improvement that had been accomplished by comparing the current rates of behaviors related to the psychiatric disorder to those present in the months and years prior to the introduction of the medication. The contemporary LBSSLC records only routinely carried forward data from the prior year. Thus, it was only by researching the historical record that this valuable information could be identified. During the Monitoring Team's onsite review, the Director of Psychiatry indicated that the 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. Following the recent departure of the Psychiatry Clerk, the Psychiatry Nurse had assumed the responsibility for maintaining this database.	

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		In summary, at the time of the 1/6/14 Polypharmacy Committee Meeting, 31 of the 123 (25%) individuals prescribed psychotropic medication at LBSSLC, met the criteria for polypharmacy. ▪ Among these 31 individuals, 17 of 123 (14%) had been placed in the "Active" category, which meant that the Psychiatry Team was still actively addressing the individual's medications. ▪ There was one individual 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 the medications, as noted above. ▪ The final category of "Stable" polypharmacy included 13 of 123 (11%) individuals for whom the Facility had determined that the 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 all of these individuals. Thus, if one accounts for the one individual who was admitted to LBSSLC from the community on multiple psychotropic medications within the last year, and the 13 individuals for whom the empirical evidence was sufficiently detailed to support the contention that their prescribed medications were necessary, there remained 17 individuals for whom current justification for their psychotropic medications could not be determined. This equated to 14 percent of the 123 individuals receiving psychotropic medication. These individuals were not noted to be experiencing any noticeable side effects from their medications. 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 17 individuals in the "Active" category were not clinically stable, and presented with complex psychiatric disorders. The Facility was still actively working to adjust the medications to improve quality of life for these individuals. The Facility was found to remain in substantial compliance with this provision, because staff continued to actively assess the individuals' need for continued polypharmacy on a monthly basis, as well as in the Psychiatric Clinics. The rate of polypharmacy that could not be justified with the empirical data had increased from eight percent at the time of the prior review to 14 percent of the total of individuals prescribed psychotropic medication at LBSSLC, as based on the calculations described above. This increase was primarily related to the migration of individuals who had been admitted to the Facility on multiple psychotropic medications from the "New Admission" category to the "Active" category, as the Facility had decided to include an individual in the "New Admission" category for only one year after admission. This may not be a sufficient amount of time	

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		to sequentially assess the efficacy of multiple psychotropic medications. In addition, some individuals, who previously had been considered to be stable, had undergone an exacerbation of their psychiatric illness, which required additional medication. Based on the reasons for the fluctuation, this degree of fluctuation in the rate of active polypharmacy is within an acceptable level. Given that the Facility had maintained a system to justify the use of polypharmacy for the "Stable" group, and continue to review and, as appropriate, challenge the regimens of the individuals in the "Active" group, the finding of substantial compliance was carried forward from the prior review.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months (per the Healthcare Guidelines). An important component of this review was also the latency between the time that the Nurse or Psychiatry Assistant completed the evaluation 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 evaluations. As noted above, since the last review, the Psychiatry Assistant had retired from this position. The Psychiatric Nurse was currently performing the DISCUS evaluations. This staff member had received training on how to utilize the DISCUS several years ago, and more recently, had gone through the training provided to the nurses at LBSSLC. In the interim, between the retirement of the Psychiatry Assistant and the beginning of the Psychiatric Nurses' employment, the two Psychiatrists performed the DISCUS on the individuals they followed in conjunction with the Quarterly Psychiatric Reviews. The staff Psychiatrist had continued to perform the DISCUS evaluations on the individuals he followed, and the Director of Psychiatry shared the responsibility with the Psychiatric Nurse. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months), and had been performed at least every six months for all 19 (100%) individuals. The review of these documents during the current and prior Monitoring Team reviews indicated that the Facility performed the MOSES on all individuals for whom they were required in the months of January and July. This policy had been implemented to increase the completion rates of those evaluations, and appeared to have been successful. The records of the 19 individuals contained documentation that the prescribing practitioner had reviewed the MOSES evaluation in a timely manner (within 14 calendar	Substantial Compliance

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		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 19 (100%) 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 were also 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 had performed the DISCUS for those individuals prescribed Reglan, and the Nurse Case Manager performed the MOSES evaluations. Based on the review of the most recent DISCUS evaluations for these individuals, the Psychiatric Nurse was now performing them. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five of the 21 (24%) individuals fitting the above criteria was selected: Individual #323, Individual #136, Individual #199, Individual #225, and Individual #62. Review of the records of these individuals indicated that the MOSES evaluations had been performed as required for all (100%) five individuals. However, the second page of the July 2013 evaluation documentation was not completed and, thus, no prescriber signature could be located for any of the following five individuals: Individual #323 (7/8/13), Individual #136 (7/9/13), Individual #199 (7/10/13), Individual #225 (7/3/13), and Individual #62 (7/8/13). The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated that these evaluations were completed as specified for all five (100%) individuals. The prescribing physician had also reviewed and signed these evaluations in a timely manner for four (80%) of the five individuals in the sample. The 11/16/13 DISCUS for Individual #199 was not reviewed and signed by the prescriber until 12/18/13. The review of the completion rates of both the MOSES and the DISCUS from the overall sample of 19 of the 123 (15%) individuals prescribed psychotropic medication indicated that these evaluations had been completed and reviewed by the prescriber, as specified for all (100%) of the individuals. These uniformly high rates of completion indicated the Facility had developed a system to routinely ensure side effect monitoring tools were	

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		completed, as specified in the Settlement Agreement. These results were consistent with those contained in the spreadsheet the Psychiatry Department maintained to track their own performance. The results of the Monitoring Team's current review indicated that those evaluations were also being performed as required for those individuals prescribed Reglan. However, there was a failure of the system related to the timely review of the sample of five individuals' MOSES evaluations performed in July 2013, because the prescriber had not signed the second pages of these documents. The finding of substantial compliance was continued due to the completion rate of the performance and review of these evaluations for the general population of 123 individuals at LBSSLC prescribed psychotropic medication. However, the Facility should investigate the circumstance surrounding the deficits related to the review of the July 2013 MOSES for the sample of five individuals prescribed Reglan, as noted above.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." For the sample of 19 of the 123 (15%) individuals prescribed psychotropic medication, 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 sources 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 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	Substantial Compliance

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	quarterly.	basis. Collaboration between the Psychiatry and Behavioral Health 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 consisted of differentiating between those behaviors that were present on a behavioral basis, from those that either represented symptoms of the psychiatric disorder or a direct manifestation of the disorder. These discussions were then carried out consistently throughout the different sections of the record and could be identified in 100 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 that 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. Efforts to monitor the efficacy of the prescribed psychotropic medication also are referred to in this provision. In all of the 19 (100%) records reviewed, empirical evidence was found that the Psychiatry Department, working in conjunction with the Behavioral Health Department, had developed an empirical system that would allow them to collectively make objective assessments of a specific medication's efficacy over time. The Quarterly Review Forms carried forward six months of behavioral data presented in tabular form, and the Behavioral Health 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. Members of the Behavioral Health Department actually collected and maintained the Behavioral Data, and the data first appeared in the PBSP data and then was transferred to the Quarterly Review documents. However, the discussions regarding which behaviors were derived from the psychiatric disorder occurred in the context of the Psychiatric	

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		Clinics, as well as informal discussions between the Behavioral Health Services Provider Assistants and the Psychiatry staff, and then were documented in the PBSP and the psychiatric documentation referenced above. The behavioral data section of the Quarterly Psychiatric Reviews included 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: "Medication Effectiveness." 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 discussed. It also should be noted that a follow-up review in one month was routinely scheduled if the individual's clinical acuity warranted a review sooner than three months. 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 could be followed on a monthly basis in between the scheduled Quarterly Reviews. This information also was incorporated routinely into the Quarterly Review document format, so that it was uniformly present in 100 percent of the records reviewed. LBSSLC Psychiatry Department and Behavioral Health Services' Progress Notes routinely carried forward two years of objective behavioral data. This was extremely valuable and clinically useful historical information. The Monitoring Team's previous report noted that 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. This information appeared in the Polypharmacy Committee minutes, where 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. In addition, each Psychiatrist maintained a "Medication Change Form," which contained the following table: *Medication Change Form* *Physician:* *Month/Year:* ***Patient Name*** | ***Medication Being Altered*** | ***Date of Change*** | ***Current Dose*** | ***Increased to*** | ***Decreased to*** | ***Rationale*** | | | | | | | | | | | | | | | | | | | | |	

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		This form was not present in the individual's active medical record, but rather each Psychiatrist maintained it in their office files, which enabled them quick access should a member of the IDT contact them seeking a Consultation. These individual, office files were continuously updated whenever the Psychiatrist was contacted about an individual or had more formal professional contact. 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 19 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. The format for the Quarterly meetings, which were observed during the Monitoring Team's current and prior onsite reviews, 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 electrocardiogram (EKG). If the individual were receiving a medication, such as a mood stabilizer, that required periodic monitoring of blood levels, these also would 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 recently had 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 Behavioral Health Services Provider representative reviewed 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 direct care professionals also provided insights into the individual's interactions in the residences. The QIDP also was present and was an active participant in the meeting. During each of the prior reviews, as well as the current review, a member of the Monitoring Team observed the Psychiatric Medication Review meetings held in the individual residences. During the current review, clinics occurred on 1/7/14 and 1/8/14. The individual meetings consisted of both monthly and quarterly follow-up reviews. The individual either attended all or a portion of the meeting, depending on	

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		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. Clinical reviews performed by each of the Facility's Psychiatrists were observed and were found to follow the format described above. 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/or if it were 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. A listing of the various documents produced for these encounters were as follows: ▪ Revised Comprehensive Psychiatric Assessment: 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 (e.g., a note commenting on an elevated blood level and the response would not have involved seeing the individual); ▪ Psychiatric Consultation – Diagnostic and Treatment Analysis: 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	

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		○ Benefit of pharmacological therapy (including past history); ▪ 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 Section J.8. The Psychiatry Department had maintained the progress it had made with the requirements specified in this section of the Settlement Agreement. This related to the continued completion of the CPAs, the Quarterly Review documentation, the "Psychiatric Consultation – Diagnostic and Treatment Analysis," and the PMTP for those individuals prescribed psychotropic medication. This documentation effectively addressed the important point of substantiating the clinical rationale for the psychiatric diagnosis and related treatment plan, as well as identifying the data needed to substantiate the efficacy of the plan, and to determine necessary changes if plans were not working. The collaboration between Psychiatry and the Behavioral Health Services Provider also had rectified the problem of the dual classification of behavior described in the Monitoring Team's previous reports. Documentation reviewed showed that Psychiatrists were reviewing individuals' treatment at least quarterly, and more often when necessary. These reviews were comprehensive in nature, and included treatment efficacy, as well as side effects of the medications. Thus, LBSSLC maintained its rating of substantial compliance with this provision, as was found during the prior review.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the records for the sample of 19 individuals receiving psychotropic medication indicated that 12 of the 19 individuals had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review 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 QIDP 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	Substantial Compliance

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		accomplished through written documentation. All consents for psychotropic medication were updated yearly. 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. As discussed with regard to other subsections, the Psychiatry Department had developed a document entitled: "Psychoactive Medication Treatment Plan." Following the transfer of responsibility for securing the consent from the Behavioral Health Services Provider to the Psychiatry Department, this document had been 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-benefit considerations were coordinated with other treatment methods and available to the IDT at the time of the annual review, as discussed with regard to Section J.8. With regard to Section J.10 of the Settlement Agreement, the Risk-versus-Benefit Analysis contained in the Psychiatry section of the record was found to be detailed and informative. Historically, this material had not been incorporated into the ISP discussions and related documentation, but as discussed elsewhere, should be summarized in the ISP. As indicated above, the Facility had developed and implemented 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 provided to the IDT uniformly for	

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		review in the ISP preparation process and subsequently discussed in the annual ISP meeting. These documents also were provided 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 remained 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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 the Following Documents**: o Section K Presentation Book, developed by Jim Forbes, Director of Behavioral Services; o On-the-Job Training (OJT) Book; o CTD Employee Training Calendar and New Employee Orientation Schedule; o Examples of DADSTX Individual Training Records; o Blank Pull Staff Member Orientation Page; o Monthly PBSP Progress Notes (December 2013), as provided during psychiatric clinic, for Individual #99, Individual #146, and Individual #299; o Internal Behavior Support Committee (BSC) and External Peer Review Meeting Notes; o Behavioral Data/Graphs, Positive Behavior Support Plan, and Structural and Functional Assessment – Consolidated Report, as provided during the Behavior Support Peer Review Committee, for Individual #264; o Behavioral Health Assessment Quality Checklist, revised 12/20/13; o For Section K.4, Positive Behavior Support Plans, Crisis Intervention Restraint Plans, Monthly PBSP Progress Notes, for three consecutive months, as provided, for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274; o For Section K.4 and K.5, Structural and Functional Assessment (SFA), Structural and Functional Assessment - Review (SFAR), and/or Structural and Functional Assessment – Consolidated Report, as provided, for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274; o For Section K.5 and K.6, Psychological Assessments or Behavioral Health Assessments, including the Inventory for Client and Agency Planning (ICAP) Evaluations, as available for: Individual #136, Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #308, Individual #97, Individual #271, Individual #139, Individual #3, Individual #240, Individual #274, Individual #75, Individual #128, and Individual #156; o For Section K.7, Psychological Assessments (including 30-day Psychological Summary), as available for: Individual #88, Individual #85, Individual #87, and Individual #91; o For Section K.8, Counseling skill acquisition programs (SAPs), monthly progress notes, and session notes, as available for: Individual #173, Individual #197, and Individual #121; o For Section K.9, Positive Behavior Support Plans, as available for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274; o For Section K.9, Behavior Support Peer Review Committee approval/review sheet,

	Informed Consent for a Positive Behavior Support Plan form, PBSPs and/or SPCIs Presented to HRC form, as provided for: Individual #184, Individual #65, Individual #140, Individual #40, Individual #97, Individual #274, Individual #165, and Individual #213; o For Section K.10, Monthly PBSP Progress Notes, for three consecutive months, as provided, for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274; o For Section K.10, Quarterly Psycho-Active Medication Review, as provided, for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274; and o For Section K.11, Positive Behavior Support Plans, as available for: Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #97, Individual #271, Individual #240, and Individual #274. ▪ **Interviews and Meetings with the following**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 1/6/14 and 1/7/14; o Tracey Snow-Murphy, Director of Residential Services, on 1/7/14; o Mary Ortiz, Director of Competency Training and Development, on 1/8/14; o Stephanie Brasfield and Denise Johnson, Unit Directors, on 1/8/14; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 1/9/14; o Sandi Kennedy, QIDP Coordinator, Section F meeting, on 1/9/14; o Marty Jones, Integrated Program Developer, and Elizabeth Elise, Integrated Program Developer, on 1/9/14; o Raul Jaime Trevino, QA Program Compliance Monitor (Section K), and Marilyn Foster, QA Program Compliance Monitor (Section S), on 1/10/14; and o Rodshadi Moore, Active Treatment Supervisor, as well as Active Treatment Coordinators Kimmie Scott-McGruder, Robbie Walker, Channing Robinson, and Brylon Bradford, on 1/10/14. ▪ **Observations Conducted**: o Specialized Class Meeting, on 1/7/14; o SAP Competency Integrity Check at the Small Workshop, on 1/7/14; o SAP Competency Integrity Check at Maple (517), on 1/7/14; o PBSP competency-based training at Oak (518), on 1/8/14; o Inter-observer Agreement (IOA) data collection at Elm (515), on 1/8/14; o IOA data collection at the Small Workshop, on 1/8/14; o Behavior Support Committee (BSC) Peer Review Meeting, on 1/9/14; o Desensitization Committee Meeting, on 1/9/14; o Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the morning, afternoon and/or evening hours at

	the following sites: ▪ Aspen (513), on 1/6/14; ▪ Oak (518), on 1/6/14 and 1/7/14; ▪ Willow (520), on 1/6/14; ▪ Small Workshop, on 1/7/14 and 1/8/14; ▪ Elm (515), on 1/7/14; ▪ Maple (517), on 1/7/14; ▪ Birch (514), on 1/7/14; ▪ Fir (516), on 1/7/14; ▪ Canna (521), on 1/7/14; ▪ Rose (525), on 1/8/14; ▪ Violet (523), on 1/8/14; ▪ Iris (527), on 1/9/14; and, ▪ Zinnia (528), on 1/9/14.
	Facility Self-Assessment: Lubbock State Supported Living Center submitted a Self-Assessment for Section K, dated 12/20/13. In the Self-Assessment, for each subsection, the Facility identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The self-assessment indicated that the Facility was in substantial compliance with four of the 13 provisions in Section K of the Settlement Agreement. These included Sections K.2, K.3, K.8, and K.11. This finding was not consistent with the Monitoring Team's current findings. That is, the Monitoring Tem found the Facility to be in substantial compliance with only three (i.e., K.2, K.3, and K.11) of the 13 provisions. Based on a review of the Facility Self-Assessment for Section K, the monitoring/audit templates (including instructions/guidelines, when available), a sample of completed monitoring/auditing tools, and interviews with staff: ▪ In the past, the monitoring/audit tools the Program Compliance Monitor used to conduct the Facility's self-assessment included those that examined the quality of the positive behavior support plan ("PBSP Review"), the positive behavior support plan monthly progress note ("PBSP Progress Note Review"), and the structural and functional assessment ("Structural and Functional Assessment Checklist). Since the Monitoring Team's last visit, it appeared that these tools were utilized sporadically. That is, provided data indicated that the PBSP Review (last used in July 2013), PBSP Progress Note Review (last used in June 2013), and the SFA Checklist (last used on July 2013) had not been completed since the end of July 2013. The competency-integrity check, including estimates of inter-rater reliability, appeared to be utilized in June, July, August, September, and November. It should be noted that, based on verbal reports from the new PCM, the lack of completion in October 2013 was due to the resignation of the previous PCM. Concurrent completion of competency-integrity checks for PBSPs by the PCM and Behavioral Service staff, including the estimation of inter-rater reliability scores, was restarted in November 2013. According to meeting minutes, inter-rater reliability scores were 97%, 98%, 97%, and 98% for June, July, August, and September, respectively. Discussions while onsite reflected an interest by the Facility in reviving the monthly use of the PBSP progress note quality checklist.

	▪ In general, the prescribed self-assessment process completed monthly by the PCM appeared to include the random selection of four individuals who had an ISP within the last two months and who also currently had a PBSP. Once identified, the PCM and Behavior Services staff would concurrently complete a PBSP competency-integrity check, including estimation of inter-rater reliability. Instructions on how to complete the check were integrated within the PBSP format. As presented above, this process appeared inconsistently implemented since the Monitoring Team's last review. ▪ Reports also indicated that, in addition to checks completed by the PCM (as described above), Behavior Health Assistants also completed approximately one competency-integrity check per PBSP per month. ▪ The self-assessment process also appeared to prescribe monthly meetings in which the PCM and the Director of Behavioral Services discussed ongoing monitoring. Provided documentation reflected several meetings in July and September between the Director and the previous PCM, and verbal reports indicated that meetings between the Director and the new PCM occurred more recently in November and December. Provided meeting minutes from November (on 11/26/13) evidenced one of these meetings. ▪ The self-assessment process, as primarily completed by Behavior Services Department (i.e., not including the PCM), also utilized other relevant data sources and/or indicators/outcome measures. For example, the current self-assessment contained many informal review processes, including review of Behavioral Services tracking grids or master lists (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 external peer review meeting minutes, data from IOA probes, integrity checks, and completed data cards, as well as record and other permanent product (e.g., counseling documents, quarterly psychoactive medication reviews, behavioral health assessments/psychological assessments) reviews. ▪ As presented above, the Facility used relevant data sources and/or was using some key indicators/outcome measures and, in general, presented data in a meaningful/useful way. However, the Facility did not provide data related to the examination of the quality of several key indicators (e.g., PBSPs, SFAs, and monthly PBSP notes).
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, progress by Behavioral Health Specialists in their pursuit of certification as Board Certified Behavior Analysts continued. In addition, the Facility continued to maintain an effective internal and external peer review system. The methods used for data collection, including data collected with regard to inter-observer agreement and competency-integrity, as well as ongoing monitoring and review continued to reflect improvement. However, progress still was needed with regard to ensuring the adequacy of monthly PBSP notes. Efforts to improve the quality of functional assessments were noted. However, a substantial number of individuals with PBSPs did not have the benefit of these improved assessments.

	Although progress was evident in adhering to the new Behavioral Health Assessment form, the Monitoring Team found no evidence of progress in updating standardized tests of intelligence and adaptive behavior. Consequently, a substantial number of assessments continued to include testing data that was outdated. Efforts at developing more effective counseling supports were evident. Progress in the development of quality PBSPs continued to be noted. However, concerns with regard to the quality of operational definitions for replacement behaviors and adequate behavioral objectives for target and replacement behaviors remained. The Facility was successful in maintaining progress in ensuring that PBSPs were written so that direct support professionals could understand them effectively. Efforts to enhance the provision of New Employee Orientation (NEO) and On-the-Job Training (OJT) to new hires were noted, and the Facility appeared to conduct competency-based training for staff on the majority of PBSPs. In addition, the Facility recently initiated a system to track and monitor those who had successfully completed CBT on PBSPs as well as other programming, which is a necessary component of the training program.

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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 Behavioral Health Specialists pursuing Board Certified Behavior Analyst (BCBA) credentialing. At the time of the current visit, six staff within the Behavioral Health Services Department had obtained their BCBAs. That is, of the 11 Behavioral Health providers, including the Director and Assistant Director, six (55%) were currently BCBAs. This reflected the recent certification of two additional BCBAs since the Monitoring Team's previous visit. Based on current verbal reports, the Director did not carry a formal caseload, and the Assistant Director carried a partial caseload. Consequently, 10 of the 11 providers in the Department currently had caseloads and developed PBSPs and, of these 10, five providers were BCBAs. 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, three Behavior Health Specialists were currently enrolled in classes and four were currently receiving necessary supervision. In addition, one Behavior Health Specialist had completed all coursework and supervision requirements, and was planning to take the exam in February 2014. The remaining Behavior Health Specialist was hired recently, and had not yet begun expected coursework and necessary supervision.	Noncompliance

		The Facility was rated as being in noncompliance with this provision because the professionals in the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Although progress had been made, currently, only six of the 11 members of the 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 Behavioral Health Specialists 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	As noted in the Monitoring Team's previous reports, LBSSLC had an internal peer review system that occurred through the weekly meetings of the Behavior Support Peer Review Committee. At the time of the Monitoring Team's previous visit, it was noted that LBSSLC policy: "Positive Behavior Support Practices," dated 4/1/13 (R), required 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) to attend. In addition, all Psychologists/Behavior Analysts were required to attend at least once per month. As previously noted, BSC was required and continued to be required to meet weekly, with the exception of major holidays. More recently, this policy was replaced by the LBSSLC policy: "Positive Behavior Support Behavioral Health Services," dated 12/5/13 (R). According to reports, this change was required to bring the LBSSLC policy into compliance with the new state level policy (#008 Behavioral Health Services Department). It should be noted that this revised policy did not include attendance criteria as previously identified and described above. Indeed, the new policy eliminated other requirements seemingly relevant to an adequate peer review process (e.g., the prescribed weekly BSC meeting schedule, annual approval duration of PBSPs, etc.). In an effort to examine the current nature of the internal peer review system, provided minutes from BSC meetings held between June and October 2013 were reviewed. This	Substantial Compliance

		sample included meeting minutes across a 22-week period from 6/6/13 to 10/31/13. Based on this review, it appeared that the BSC met at least once each week for 19 (86%) of the 22 possible weeks. However, one of the three weeks in which the BSC did not meet included the 4th of July holiday. More specifically, the holiday fell on the regularly scheduled weekday (i.e., on Thursday when the meeting was typically scheduled). Consequently, it appeared that the BSC met at least once each week, except for major holidays, for 19 of the 21 weekly scheduled meetings. It should be noted that an additional BSC meeting was held during the 3rd week of July likely as a "make-up" meeting. In total, there were 20 of the 22 expected BSC meetings held during this time period (91%). Meeting minutes revealed that the Director and/or Assistant Director of Behavioral Health Services, both of whom were BCBAs, attended all (100%) of the BSC meetings. Closer examination revealed that the Director, Assistant Director, and two other BCBAs attended 75%, 85%, 95%, and 80% of the meetings, respectively, over this time period. Overall, three or more BCBAs were in attendance at 17 (85%) of the meetings and, since the recent certification of two additional BCBAs (on 9/30/13), four or more BCBAs were in attendance for all (100%) of the last five meetings. The estimated average (and range) attendance at meetings for current Behavioral Health Specialists and Behavior Services Assistants was 55% (30% to 80%) and 16% (5% to 30%) of the meetings, respectively. It should be noted that the estimate of attendance for Assistants might underestimate actual attendance due to the moderate turnover in the position. Overall, three or more Behavioral Health Specialists were in attendance at 18 (82%) of the meetings, and one or more Behavioral Services Assistants were in attendance at 17 (77%) of the meetings. Although no longer required by current policy, attendance by QA/QI staff, one or more speech language professionals (SLPs), and the Human Rights Officer was 75%, 90%, and 25% of meetings, respectively. Overall, adherence to the weekly BSC schedule, as well as supervision by the Director or Assistant Director of Behavioral Health Services at those meetings remained satisfactory. In addition, attendance by other BCBAs was also viewed as satisfactory. BSC meeting minutes also evidenced very detailed peer review and critique, including the provision of specific feedback and recommendations, of several documents, including graphs, Structural and Functional Assessments, Positive Behavior Support Plans, Skill Acquisition Plans, and Crisis Intervention Plans. Indeed, meetings minutes consistently demonstrated an ongoing active, critical review of behavioral programming. The internal peer review process continued to be supplemented by the utilization of an external peer review process as well. As reported in the Monitoring Team's previous	

		reports, faculty and students from Texas Tech University continued to provide consultation and conduct intensive projects aimed at improving behavior services (e.g., monitoring of data collection). In addition, the faculty member, a Doctoral-level BCBA (BCBA-D), provided external peer review through his participation in BSC as well. Based on provided BSC meeting minutes (as described above), it appeared that the BCBA-D participated in one (5%) of the BSC meetings between 6/6/13 and 10/31/13, 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 available external peer review meeting minutes over the past six months (i.e., between 6/21/13 and 11/14/13), it appeared that one external peer review meeting involving Behavioral Health Providers, including BCBAs, from other SSLCs and/or State Office, was held each month. Closer examination of meeting minutes revealed that AUSSLC, ABSSLC, CCSSLC, and the Discipline Coordinator from the State Office participated as external reviewers in three (50%), five (83%), four (67%), and six (100%) of these scheduled meetings, respectively. It should be noted that the November meeting appeared to only include the State Office Discipline Coordinator. The Director of Behavior Health Services participated in six (100%) of the scheduled meetings. In addition, the Behavioral Health Specialists or BCBA responsible for presenting the identified case attended each meeting as well. Provided documentation evidenced in-depth case reviews, including examination of the purpose of the review, referral question, background, behavioral history and alternative behavior, current psychiatric diagnosis, cognitive and adaptive behavior status, and current status, as well as a summary of discussion and feedback, including specific recommendations. Based on documentation, it appeared that the peer reviewers critically examined behavioral programming, including SFAs, PBSPs, Behavioral Health Assessments, behavior data (graphs), and/or CIPs, as well as actively engaged in discussion and provided feedback. Overall, this external peer review process appeared satisfactory and documentation continued to suggest that sufficient external peer review was being maintained. Overall, the Facility continued to maintain an effective internal peer review process through the BSC as well as through the utilization of qualified external supports to provide ongoing external peer review. Based on the findings presented above, the Monitoring Team continued to find 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	As described in the Monitoring Team's previous reports, the Facility had worked to improve the effectiveness of a standardized data collection system that utilized index cards to allow staff to immediately record data on target and replacement behaviors. This system had been developed and implemented through the collaborative efforts of the Facility and faculty/students from Texas Tech University. That is, this collaboration	Noncompliance

	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.	facilitated planned efforts aimed at improving the use of the data card system. As reported in the Monitoring Team's last report, improvement in the use of the data cards was reported in some of the settings targeted. However, compliance rates remained below 50% for most programs. At that time, it was believed that submission rates likely under-estimated compliance given the project's stringent inclusion criteria. Currently, the collaboration was still in effect, and, based on data provided within Section K of the Facility's Self-Assessment, dated 12/20/13, as well as within the Section K Presentation Book, improvement in compliance rates was again reported for some programs. It should be noted that, as part of this project, the programs were divided into three groups and the residences within each group received one or more interventions (up to four), implemented sequentially, utilizing a multiple baseline design. Currently, given the nature of the design, Group 1, Group 2, and Group 3 had received four, three, and two of the interventions, respectively. Summary data revealed that the programs that received the most interventions had the highest compliance rates. More specifically, Group 1's (Homes 1-5) data reflected increasing trends and rates consistently above 70% for all homes in October and November. Group 2's (Homes 6-10) data reflected increasing trends for all home and rates consistently above 50% for four of five homes for September, October, and November. Group 3's (Homes 11-15) data reflected an increasing trend and rates consistently above 50% for one of five homes for August and September. However, it was unclear if this progress had been maintained as data was "... not presented due to infection control home access procedures confounding the process." Although this appeared to be a legitimate issue, it was unclear to the Monitoring Team whether or not the omission of October and November data was due to the data not being collected or that a change in compliance rates due to confounding factors (i.e., complications related to infection issues) was the basis for non-reporting. Overall, it appeared that the increasing combination of interventions was effective in improving compliance concurrent with their implementation. As the project continued, it was expected that the remaining homes would similarly respond once exposed to the remaining interventions. 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. As described in the Monitoring Team's previous reports, the Facility also collaborated with Texas Tech University in the past to improve the quality of monthly PBSP progress notes. As previously reported, this project involved examining the effectiveness a PBSP Progress Note Review rubric used to improve (and monitor) the quality of monthly PBSP progress notes. Previously reviewed documentation revealed that this rubric and its ongoing use (i.e., monthly performance feedback) significantly improved the quality of PBSP progress notes. Currently, the Facility reported that this project had been discontinued since the Monitoring Team's last onsite visit. Verbal reports from the Director of Behavioral Health Services, however, indicated that the Program Compliance	

		Monitor and Behavioral Health Services would likely re-implemented this rubric in a similar effort to ensure the quality of monthly PBSP progress notes going forward. 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 Monthly PBSP Progress Notes for 13 individuals, who had an ISP meeting within the last six months and who also had PBSP, were selected. Based on the PBSP Master List, dated 12/12/13, this sample of 13 individuals reflected 10% of total number (N=133) of individuals with active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from September, October, and November 2013, as available. Review of provided documentation indicated: ▪ Monthly PBSP Progress Notes were completed across September, October, and November for 13 (100%) individuals; ▪ At least one target behavior and at least one replacement behavior were displayed in monthly PBSP progress notes for 11 (85%) of the individuals sampled. The exceptions included one or more progress notes where the replacement behavior(s) were not identified, defined, and/or graphed for Individual #184 and Individual #87. In addition, the replacement behaviors identified, defined, and graphed for Individual #140 appeared to have considerable overlap. Consequently, only 10 (77%) of the monthly notes appeared to adequately display one or more target and replacement behavior; ▪ Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 11 (85%) of the individuals sampled. Exceptions included the monthly notes for Individual #140 and Individual #87, 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 seven (54%) of the individuals sampled. However, it should be noted, that PBSPs were completed in December or January (i.e., sampled monthly notes were completed prior to the revision of the PBSPs) for four of the individuals sampled (i.e., Individual #184, individual #170, Individual #245, and Individual #87). Consequently, of the nine individuals with PBSPs completed prior to the completion of the sampled monthly notes, seven (78%) appeared to contain target and replacement behaviors that were consistent across documents. The exceptions included Individual #97 and Individual #140; ▪ Inclusion of monthly IOA estimates, including actual data, were found in at least one monthly note for 11 (85%) of the individuals sampled. The exceptions included Individual #240 and Individual #274. A review to examine consistency across all three months revealed monthly IOA estimates, including actual data, were found in all three monthly notes for seven (54%) individuals. The exceptions were Individual #184, Individual #40, Individual #87, Individual #271, Individual #240, and Individual #274. It should be noted that IOA data was expected to be completed for each PBSP and reported each month in PBSP	

		Monthly Notes; ▪ Inclusion of monthly competency-integrity estimates, including actual data, were found in at least one monthly note for 13 (100%) of the individuals sampled. A review to examine consistency across the three months revealed that competency-integrity estimates, including actual data, were found in all three monthly notes for eight (62%) individuals. The exceptions included Individual #184, Individual #109, Individual #40, Individual #271, and Individual #274. It should be noted that competency-integrity estimates were expected to be completed for each PBSP and reported each month in PBSP Monthly Notes; ▪ Monthly notes contained timely target and/or replacement behavior data for 11 (85%) of the individuals sampled. The exceptions were the September note for Individual #271, and the November note for Individual #274; ▪ Monthly notes appeared to be completed and reviewed in a timely fashion (within 30 days) for nine (69%) of the individuals sampled. The exceptions were the September note (signed in November) for Individual #140, the September note (included October data and not dated) for Individual #271, the November note (missing data) for Individual #274, and the October note (not signed) for Individual #97; ▪ Overall, the clinical notes appeared to be descriptive, integrative and offered clinical insight (beyond the graphed data) in the monthly notes for 10 (77%) of the individuals. Exceptions included the seemingly copied narrative for Individual #274 and Individual #140, as well as incomplete comments for Individual #184. Based upon the current review of sampled Monthly PBSP Progress Notes, continued improvement was noted. More specifically, monthly notes appeared improved with regard to the inclusion of target and replacement behavior data, including IOA and integrity data, as well as meaningful summaries of current functioning as well as implications for behavioral programming. However, concerns were still noted with regard to consistency between the notes and the current PBSP, consistent inclusion of IOA and integrity data, and the timeliness of review. More specifically, the current review of monthly PBSP progress notes evidenced improvement in the inclusion of IOA and treatment integrity data for the majority of individuals sampled. However, this data was not consistently found in all of the sampled monthly notes as expected. Additional information regarding progress in ensuring the reliability of data and treatment fidelity is provided with regard to Sections K.10 and K.12 of the Settlement Agreement, respectively. Data provided within the Self-Assessment for Section K.4 evidenced that the Facility was monitoring the number of monthly PBSP progress notes completed per month. That is, summary data on the number of PBSP progress notes completed per month between May and October 2013 was displayed. Data revealed that 132, 124, 125, 117, 107 and	

		100 monthly progress notes were completed in May, June, July, August, September, and October, respectively. Given that the total number of PBSP ranged from 133 to 136 during this time period, it appeared that a high percentage (i.e., approximate range of 74% to 98%) of progress notes were completed each month. The Facility reported that the lower score reported in October was due to a data entry error. Consequently, the estimated percentage of completed monthly progress notes might underestimate the actual amount. However, it was clear from previous and current discussions with the Behavioral Health Services staff that a PBSP monthly progress note was required for each PBSP. Given this expectation, it appeared that continued improvement in the completion of monthly progress notes for all individuals with PSBPs was still necessary. In addition, as discussed above, the quality of the monthly PBSP progress notes had not been systematically monitored as previously observed, and plans appeared to be in place to restart that practice. Consequently, going forward, it was expected that systems to monitor both the quality and timely completion of these notes would be in place at the time of next Monitoring Team's onsite visit. 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 Behavior Health Specialist or Behavior Analyst's review of behavioral data. Of the 13 PBSPs reviewed, one appeared to be revised due to changes observed in behavioral functioning (i.e., Individual #40). Similarly, of the 13 SFA/SFARs reviewed, one appeared to be revised due to behavioral observations necessitating revisions to assessment and intervention for a new target behavior (Individual #40). In general, based on the sample, the practice of revising functional assessments and/or PBSPs appeared, at times, related to observations of behavioral functioning. However, for most individuals sampled, revisions appeared primarily rooted within the ISP meeting schedule. As reported in the Monitoring Team's previous reports, the Facility no longer developed and implemented Safety Plans for Crisis Intervention (SPCI). In their place, IDTs facilitated the development and integration of Crisis Intervention Plans (CIPs) 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, two individuals with CIPs were sampled and recent Monthly PBSP progress notes (from September, October, and November) were reviewed. This included the CIPs and monthly notes of Individual #240 and Individual #213. Based on data listed with "Crisis Intervention Restraint Plans," dated 5/15/12 through 11/15/13, this sample reflected 20% of the total (N=10) number of individuals with CIPs. Review of monthly notes indicated that data on restraint use (frequency data) within the sampled monthly PBSP progress notes was evident for the individuals sampled.	

		Overall, the methods used for data collection, including data collected with regard to IOA and competency-integrity, as well as ongoing monitoring and review continued to reflect improvement. However, progress still was needed with regard to ensuring the adequacy of monthly PBSP notes. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure consistency between PBSPs and monthly notes, consistent reporting of IOA and integrity data each month, and timely 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.	As observed during the Monitoring Team's previous reviews, screening for psychopathology, emotional, and behavioral issues was completed either through the psychiatric clinic's completion of a psychiatric assessment or the completion of the Reiss Screen for Maladaptive Behavior to screen for the need for 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. As detailed in the Monitoring Team's previous reports, in addition to the completion of traditional psychological assessments, the Facility also completed Structural and Functional Assessments. 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. In addition, individuals who received behavioral and/or psychopharmacological interventions were required to have this assessment completed in an effort to promote a better understanding of the nature of maladaptive responding, and develop more effective and individualized behavioral interventions. Since the Monitoring Team's last visit, the new Behavioral Health Services policy, dated 12/6/13, had been formally implemented by the Facility on 12/20/13. In accordance with this new policy, SFAs must include specified components, for example, including: 1) description of challenging behavior, including topography, co-variation with other responses, and precursors; 2) potential setting events and motivating operations; 3) antecedent and consequence; 4) functions, including derivation; 5) functional replacement behavior and alternative responses; 6) preferences and potential reinforcers; 7) response to previous and current interventions, including data; and 8) specific recommendations and justifications. The new policy as well as the required components with regard to SFAs is discussed below. As noted in the Monitoring Team's previous reports, the Facility utilized both the "Structural and Functional Assessment" and "Structural and Functional Assessment Review." The later format was developed to assist Behavioral Health Specialists 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	Noncompliance

		the various factors that might necessitate a re-evaluation and subsequent completion of a more current SFA. In addition, the Structural and Functional Assessment Self-Monitoring Checklist was developed to insure that SFAs were adequately developed. Currently, it appeared that this checklist was recently revised, dated 10/23/13, and was now titled the "Structural and Functional Assessment Checklist." In addition to the new format for SFA, an addition document titled the "Consolidated Structural and Functional Assessment" was created to address inadequacies identified within previously completed SFAs and SFARs. More specifically, the Consolidated Structural and Functional Assessment was designed to contain all of the necessary elements found within an SFA and was used to replace previously completed SFAs/SFARs that were previously found to be lacking. These new formats and related implications for the current review are discussed below. Currently, according to the PBSP Master List, dated 12/12/13, approximately 124 (93%) individuals with PBSPs had an SFA or SFAR completed within one year of BSC approval of the PBSP. According to summary documentation, the exceptions included the following nine individuals (i.e., Individual #88, Individual #23, Individual #165, Individual #274, Individual #82, Individual #87, Individual #245, Individual #232, and Individual #299), three of whom were recently admitted to the Facility. In an effort to more closely examine the nature of current functional assessments, provided SFAs, SFARs, and/or Consolidated SFAs for 13 individuals with ISP meetings completed within the last six months and with PBSPs were selected. This sample of 13 individuals reflected 10% of the total number of individuals with PBSPs (N=133). Review of available assessments revealed that a SFA, SFAR, and/or Consolidated SFA was/were completed within the last 12 months for 13 (100%) of those sampled. Closer examination of the most recently dated assessments revealed that, of the 13 individuals selected: 1) an SFAR completed using the older format, dated 8/3/12, was provided for eight (62%) individuals (i.e., Individual #109, Individual #111, Individual #170, Individual #140, Individual #97, Individual #271, Individual #240, and Individual #274); 2) an SFAR completed using the most recently revised format was provided for four (31%) of the individuals (i.e., Individual #184, Individual #245, Individual #40, and Individual #87); and 3) a Consolidated SFAR was completed for one (8%) individual (i.e., Individual #65). According to data provided in the Self-Assessment regarding Section K.5, the Facility provided similar percentages to those found in the current sample described above. More specifically, the Facility reported that only 36 (27%) of current SFA/SFARs were in the current format and that only 14 (14%) of the remaining outdated SFA/SFARs were completed in the Consolidated SFA format. Based on findings detailed within the Monitoring Team's previous reports regarding the inadequacies of the older SFAR format and based on the Facility's emphasis on completing SFARs using the most recent format as well as completing Consolidated SFAs,	

		only those assessments completed using these most current formats were examined. That is, only the four SFARs completed within the new format (i.e., for Individual #184, Individual #245, Individual #40, and Individual #87) as well as the single Consolidated SFA (for Individual #65), for a total of five assessments were currently reviewed. Based on summary data provided in the Self-Assessment regarding Section K.5, this sample of five assessments represented four (11%) of the 36 SFAs identified by the Facility as completed in the current format and one (7%) of the 14 completed in the Consolidated SFA format. Review of the five sampled comprehensive psychological assessments indicated that five (100%) reported using a standardized process, including interviews, rating scales, and/or direct observation, widely accepted within behavior analysis. Of these five assessments, five (100%) included operational definitions of target behaviors, as well as potential precursor behaviors and descriptions of observed covariation. In addition, five (100%) included identification of likely setting events/motivating operations, preferences, and reinforcers. In addition, five (100%) highlighted whether or not the behaviors were learned or biologically driven, identified potential antecedents and consequences, and described/summarized potential functions relevant to problematic behavior. Also, five (100%) identified functionally equivalent replacement behaviors, referenced the individual's response to current and/or previous interventions, and included IOA and treatment integrity data. Lastly, all five (100%) included information describing any necessary accommodations, relevant recommendations, and were signed and dated. Overall, it appeared that this format provided a structure in which to comprehensively review relevant variables in preparation for developing an effective PBSP with interventions informed by findings from a comprehensive assessment. It was clear that special emphasis was placed on the inclusion of data related to inter-observer agreement and treatment integrity. However, one concern was noted with regard to the review of other data found within these reports. That is, although current IOA and competency-integrity data was found in all of the assessments, review of current behavioral data was only conspicuous in four (80%) of the assessments reviewed. More specifically, the SFA for Individual #40 did not reference or cite any current behavioral data or any current indirect or direct assessment data. Indeed, the section devoted to "response to PBSP" did not appear to review of any current data and only vaguely referenced the PBSP's general effectiveness in relation to challenging behaviors. In general, it appeared that progress was made in the improvement of the quality of functional assessments. However, there continued to be a substantial number of individuals at LBSSLC that had PBSPs, but did not have the benefit of these improved assessments. Focus on updating individuals' assessments to these newer formats was needed. In addition, to move in the direction of substantial compliance, the Monitoring	

		Team recommends that the Facility ensure that current data, in addition to IOA and competency-integrity data, be incorporated into the SFA/SFARs and Consolidated SFAs when appropriate, especially with regard to review of the PBSPs effectiveness.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Since the Monitoring Team's last visit, on 12/20/13, the Facility had implemented the new Behavioral Health Services policy, dated 12/6/13. In accordance with this new policy, Behavioral Health Assessments must include specified components, including, for example, information on: 1) intellectual/cognitive ability; 2) adaptive ability; 3) psychopathology, emotional or behavior issues; 4) information on biological, physical, and medical status related to behavioral and psychological functioning; and 5) review of personal history. This new assessment had a prescribed format that, based on review of sampled assessments, included additional information (e.g., active problem list, risk levels). The new policy indicated that this assessment must be reviewed annually and as needed by behavioral health providers. This annual review would appear to include updating information and summarizing current progress. If a clinically significant change in status were noted, the assessment would be reviewed and the behavioral health provider would make a recommendation to the IDT regarding reassessment on one or more components of the behavioral health assessment. This reassessment would be completed within time frames prescribed by the IDT. Currently, it was unclear to the Monitoring Team how an IDT would identify or determine if a change in status was "clinically significant," and how an IDT would determine which component would be targeted for reassessment. In addition, it was unclear how the behavioral health provider would determine which standardized assessments would be acceptable when reassessing intellectual and/or adaptive ability. Indeed, language in the new policy was clear with regard to which instrument would be required to screen for psychopathology, emotional, or behavioral issues (i.e., the Reiss Screen for Challenging Behavior or equivalent). However, the same level of specification was not found with regard to standardized tests of intelligence or adaptive functioning. In addition, previous reviews noted that, in some cases, estimates of intellectual and/or adaptive functioning were based on testing completed several decades earlier. Given the current policy, it would appear that these scores would remain in place until a clinically significant change in status was observed. The Monitoring Team questioned if scores based on testing completed decades earlier, for example, would serve as meaningful and accurate baselines. Indeed, the policy asked behavioral health providers to consider "how old the testing is" when assessing individuals newly admitted, but did not provide guidance on "how old the testing is" for individuals currently residing at the Facility. Interesting, the policy did prescribe specific guidelines (i.e., every three years) for testing timelines for individuals younger than 18 years of age. Lastly, the Monitoring Team questioned the sensitivity of the IDTs in detecting changes in status or functioning without the use of regular assessment, especially adaptive testing.	Noncompliance

		The new policy was clear on the requirement that each individual residing at LBSSLC have a Behavioral Health Assessment. This included reviewing results from the Inventory for Client and Agency Planning (ICAP) evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years, or sooner, if significant events appeared to impact adaptive functioning. To determine whether or not previous Psychological Assessments or, more recently developed, Behavioral Health Assessments were based on current, accurate, and complete clinical and behavioral data, Psychological Assessments, Behavioral Health Assessments, and ICAP documentation, as provided, from a sample of 20 individuals was examined. This sample was selected from those who had an ISP meeting within the past six months and included individuals selected from across most residential programs in an effort to ensure a representative sample. Given the current census of 202 individuals at the time of the current visit, this sample reflected approximately 10% of the total number of psychological assessments. Based on the current sample as described above, of the Psychological Assessments or Behavioral Health Assessments reviewed, 20 (100%) were updated within the last 12 months. It should be noted that 10 (50%) of the assessments were completed using the new Behavioral Health Assessment format, dated 8/30/13, which had been completed since late September 2013. In addition, 19 (95%) of the assessments were completed prior to the ISP meeting. The exception was the assessment completed for Individual #139. These findings were consistent with data the Facility provided. That is, provided data as listed on one of the behavioral health services tracking spreadsheets (i.e., Psychological/Behavioral Health Assessments, dated 12/12/13) revealed that 92 assessments had been completed since 6/17/13, and that only two (less than 1%) assessments were out-of-date at that time. Off-site comparison of this summary data with sampled documentation reflected 100% correspondence between the dates listed on the tracking data sheet and dates listed on the sampled documents. Provided documentation revealed that, of the behavioral health assessments or psychological assessments reviewed, 20 (100%) of the sampled individuals had an ICAP evaluation completed within the last three years. However, it was unclear why a more recently completed ICAP, dated 10/29/13, was not included in the Behavioral Health Assessment completed for Individual #245. Of the individuals sampled, 19 (95%) 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. The exception included an assessment where testing results did not reflect typical standardized intellectual assessment (i.e., the assessment for Individual #3). However, typical intellectual assessment was not likely appropriate given the individual's current disabilities. Of the 20 individuals sampled, only eight (40%) reported findings based on intellectual testing completed within the last five years. The	

		exceptions included psychological assessments for 12 individuals that contained testing results that were five or more years old (i.e., Individual #136, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #308, Individual #139, Individual #3, Individual #247, and Individual #128). Of the 20 sampled Psychological Assessments or Behavioral Health Assessments, tests of adaptive functioning (i.e., Vineland Adaptive Behavior Scales) were reported in 19 (95%) assessments. The exception included the assessment for Individual #274, where results of adaptive behavior scales, other than the ICAP, were not reported. Of the 20 individuals sampled, only nine (45%) reported tests of adaptive behavior scales (other than the ICAP) completed within the past five years. The exceptions included psychological assessments for 11 individuals that contained testing results that were five or more years old (i.e., Individual #136, Individual #65, Individual #109, Individual #111, Individual #170, Individual #245, Individual #308, Individual #139, Individual #3, Individual #247, and Individual #128). The Monitoring Team's previous report noted that no new testing (i.e., standardized tests of intelligence and/or tests of adaptive behavior) had been completed since February 2013. At that time, provided documentation (i.e., testing dates) as well as verbal reports from the Director of Behavioral Health Services indicated that new testing was "put on hold" based on directives from State Office. That is, 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. Currently, based on the Record of Psychological Testing, no new testing (i.e., other than the ICAP) had been completed since February 2013. Information provided in the Section K Presentation Book related to Section K.6 indicated that the ICAP was the only assessment of adaptive behavior recently utilized. However, verbal reports from the Director of Behavioral Health Services indicated an expectation that a more rigorous standardized instrument like the Vineland Adaptive Behavior Scale would be utilized to assess adaptive functioning in the future. In addition, verbal reports indicated that a thoughtful, prioritization of testing, targeting individuals with missing testing or inadequate testing results, would be initiated and the results were to be conspicuous at the Monitoring Team's next visit. This stated approach appeared reasonable, and one that would benefit the individuals LBSSLC supports. Overall, although progress was evident in adhering to the new Behavioral Health Assessment form, the Monitoring Team found no evidence of progress in updating standardized tests of intelligence and adaptive behavior. Consequently, a substantial number of assessments continued to include testing data that was outdated. 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 scale, including ensuring that recent testing results are adequately described/summarized to facilitate the potential treatment utility of Behavioral Health Assessments. In addition, the Facility should continue to revise previous psychological assessments utilizing the new Behavioral Health Assessment format, including use of the new Behavioral Health Assessment Quality Checklist.	
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 noted in the Monitoring Team's previous reports, the LBSSLC policy required that a psychological assessment be completed one month from the date of an individual's admittance. Since the Monitoring Team's last visit, four individuals were admitted to the Facility, including Individual #88, Individual #85, Individual #87, and Individual #91. In an attempt to examine whether or not psychological assessment(s) of each individual was completed within 30 days of admission, the psychological assessment of each individual admitted since the Monitoring Team's last visit was reviewed. It should be noted that psychological assessments were provided for three of the four individuals. That is, a psychological assessment for Individual #91 was not provided for review as requested. However, given that Individual #91 was admitted less than 30 days from the time of the request (made during the Monitoring Team's onsite visit), it was entirely possible that the assessment had not yet been completed. Based upon review of the three available psychological assessments, three (100%) were completed within 30 days of admission. Of these, three (100%) had an ICAP completed within the last three years. In addition, three (100%) had results of previously completed standardized tests of intelligence. However, only two (67%) of these had intelligence tests completed within the last five years. The exception was Individual #88. In addition, two (67%) of the three assessments had results of previously completed standardized tests of adaptive behavior (i.e., not including the ICAP). The exception was Individual #88. Of these two, two (100%) had adaptive testing completed within the last five years. It should be noted that standardized tests of intelligence and adaptive behavior were not completed for any of the individuals within 30 days of admission. In general, the sampled psychological assessments included a brief review of previous testing as well as other relevant information including, for example, psychosocial history, descriptions of mood and affect, brief review of behavioral concerns, relevant diagnoses, and recommendations. Since the Monitoring Team's last visit, on 12/20/13, the Facility had formally implemented the new Behavioral Health Services policy, dated 12/6/13. However, all four of the individuals admitted to the Facility since the Monitoring Team's last visit entered prior to the formal implementation of the new policy. Consequently, going forward, any new individuals admitted between the last and next onsite visits will be reviewed in accordance with the new policy. As previously presented with regard to Section K.6 of the Settlement Agreement, the policy appeared to lack sufficient specification when prescribing behavioral health providers to consider whether or not	Noncompliance

		testing instruments and/or testing results were appropriate to the individual, complete and current. Overall, documentation revealed that all new admissions had a psychological assessment completed within 30 days of admission. However, one of these assessments contained outdated tests of intelligence and adaptive behavior. In addition, as discussed with regard to Section K.6, the annual assessments for individuals were not of adequate quality. 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 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.	Based on verbal report and provided documentation, it appeared that four community-based counselors provided counseling services to six individuals, as of 12/9/13. As reported within the Section K Self-Assessment, all six individuals received counseling from appropriately credentialed counselors, including three Licensed Professional Counselors and one Licensed Marriage and Family Counselor. To more closely examine the nature of these psychological services and supports, counseling skill acquisition program, as well as monthly counseling progress notes and weekly session notes, for the last three months (i.e., September, October, and November), as available, were reviewed for three individuals currently receiving counseling supports. This sample represented 50% of those individuals (N=6) currently receiving counseling services. It should be noted that the Facility indicated that in October 2013, these SAPs, and related progress notes were recently revised. Consequently, only a limited sample of recently revised permanent products was currently available for review. Of the three individuals, the following was found: ▪ Three (100%) had counseling skill acquisition programs. These programs were recently revised in September (Individual #121), October (Individual #173) and November (Individual #197); ▪ 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, and concerns with the objectives were noted. More details are provided below; ▪ Three (100%) had a counseling skill acquisition program in which one or more replacement behaviors were identified. However, none (0%) of the replacement behaviors appeared to be adequately defined within the counseling skill acquisition programs as initially purported. More details are provided below; ▪ 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; ▪ Three (100%) had a counseling skill acquisition program that conspicuously identified a therapist, setting, and schedule (including session length) for	Noncompliance

		counseling sessions; ▪ Three (100%) had a counseling skill acquisition program that specified data collection and measurement procedures. However, concerns were noted with the adequate adherence to identified procedures. More details are provided below; ▪ Three (100%) had weekly sessions notes completed for counseling sessions conducted since this new system was implemented in October. That is, weekly session notes ("Counselor's Data from Counseling Sessions") provided during October and November were reviewed. Some concerns were noted regarding their adequate completion. More details are discussed below; and ▪ Three (100%) had monthly Counseling SAP Progress Notes completed for October and November. However, concerns were noted and are discussed below. Overall, it appeared that since the Monitoring Team's last visit, Counseling Skill Acquisition Programs, weekly session notes (i.e., "Counselor's Data from Counseling Sessions"), and monthly Counseling SAP progress Notes were significantly revised. These revisions appeared to be an improvement compared to previously reviewed documents. In addition, all of the revised formats and content appeared similar across all individuals sampled. The noted changes appeared likely to facilitate a higher quality SAP, as well as more effective monitoring of responding both within and outside of the counseling sessions. Indeed, the Facility's efforts to improve counseling supports were noted. And, although the standardization of these documents and related processes across individuals is likely to be beneficial in many ways, inherent limitations consequently appeared equally problematic. As presented above, concerns were noted with regard to several sections of the sampled documents. More specifically, inadequacies within counseling objectives, operational definitions, and data monitoring were observed. These are described below using one of the individuals (i.e., Individual #121) as a representative example. It should be noted that the identified inadequacies were consistently identified across all three of the individuals sampled: ▪ The operational definition of replacement behaviors for Individual #121 was vague. Although the treatment objectives appeared improved, as they seemed to target both verbal and non-verbal responses, it was still unclear, given the provided operational definition, what the specific replacement behaviors included. Indeed, even examples of these were not offered. That is, the operational definition described "… [Individual #121] states a way to use her PBSP's replacement behavior …" but does not actually indicate which ways (or potential examples of ways) might be acceptable or accurate. It should be noted that the counseling SAP directed the counselor to the PBSP for the most current operational definition. Unfortunately, the current PBSP was not provided to the Monitoring Team for review. In addition, the replacement behaviors might likely be operationalized on the Counseling Generalization SAP as well.	

		However, this SAP also was not provided for review. Nonetheless, the rationale found within the counseling SAP specifically indicated that the SAP " … was revised to make definitions operational, to make definitions more easily recognized and prompted by non-clinical staff…" and that the SAP "… identifies non-verbal replacements responses …". These revisions, including specific identification of non-verbal replacement responses, were not conspicuous in the provided counseling SAP. In addition, the revisions should include efforts to make "responses," not definitions, more easily recognized and prompted by non-clinical staff. ▪ The generalization and maintenance sections in the counseling skill acquisition programs for Individual #121 appeared improved. As previously noted, related supplemental SAPs, referred to as Counseling Generalization Skill Acquisition Programs, appeared to have been developed and implemented in an attempt to facilitate generalization of skills into settings external to the formal counseling session. However, Counseling Generalization SAPs and related completed SAP data sheets were not provided for the Monitoring Team's review. ▪ The revised Counseling SAP Progress Notes appeared significantly improved as they included, for example (i.e., for Individual #121), not only sections on the counseling SAP objectives and operational definitions, but also analysis of data, including tabular and graphic display of replacement behaviors (e.g., in-session and out-of-session, as well as the number of sessions scheduled as well as attended), and specific recommendations. It should be noted, however, that the generalization (out-of-session) data displayed in the current SAP Progress Notes could not be confirmed, because the Counseling Generalization SAP and related data sheets were not available for review. Nonetheless, it appeared this revised, more comprehensive data monitoring and review process (initiated in October 2013) was a substantial improvement. It should be noted that, because these revisions only recently occurred, the Monitoring Team's review of ongoing data collection and monitoring processes was limited to two or less months of data. Lastly, the Counseling Skill Acquisition Programs prescribed the collection of weekly session notes by counselors. A revised session note, called Counselor's Data from Counseling sessions, was used by the counselors to record individual performance during the session, including number of antecedents identified (either by the counselor or the individual), the number of correct verbal descriptions of replacement behaviors (in response to specific antecedents), and the number of scheduled as well as attended sessions. This revised data form appeared to offer an efficient and effective way to collect data on a number of important variables. However, some concerns were noted with the adequacy of the data collection for two of the three individuals sampled. For example, the data recorded (i.e., number of times replacement behavior was used in response to antecedents) on the counselor session forms for 10/25/13, 11/7/13, and 11/15/13 did not correspond to the data reported on the October and November 2013	

		monthly SAP progress notes for Individual #197. Similar findings were noted with regard to inadequate data collection on counselor session forms for 11/1/13 and 11/22/13 for Individual #121. Overall, the revisions described above appeared to reflect progress in developing more effective counseling supports and, once the "bugs" are worked out, this new process is likely to dramatically impact the acquisition and demonstration of adaptive responses both within and external to formal counseling sessions. 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. In the past, non-evidenced based types of therapeutic services (e.g., sensory diet, body sock, sensory room) had been noted. Consequently, previous recommendations to the Facility included ensuring that all psychological supports and services adhered to rigorous, evidenced-based standards. In response, the Facility had revised the previous policy (e.g., the Positive Behavior Support Practices, 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. Currently, similar language emphasizing that behavioral health services are based on current evidenced-based research was integrated into the new "LbSSLC – Positive Behavior Support Behavioral Health Services" policy, dated 12/6/13 (R). The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ameliorate the remaining concerns (as described above) with regard to the newly revised counseling treatment plans as well as data collection procedures and, subsequently, maintain a high level of quality with counselors and direct support professionals' implementation of them.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days	It an attempt to examine the current status of active PBSPs, a sample of 13 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 12/12/13, this sample of 13 individuals reflected 10% of total number (N=133) of individuals with active PBSPs. Of the 13 individuals sampled, 13 (100%) had PBSPs completed using the most recent PBSP format. Based on review of the PBSP, of the 13 individuals, the following was found: ▪ 13 (100%) appeared to be based on a completed SFA or SFAR. However, as previously described with regard to Section K5 of the Settlement Agreement, the majority of sampled SFA/SFARs were completed using a previous format. These included the assessments for Individual #109, Individual #111, Individual #170, Individual #140, Individual #97, Individual #271, Individual #240, and Individual #274;	Noncompliance

	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.	▪ 13 (100%) included a rationale for development or revision of the PBSP; ▪ 13 (100%) included one or more operational definitions of target behavior(s). However, one of these appeared inadequate (i.e., Individual #184). As a result, 12 (92%) appeared to include adequate operational definitions of target behaviors; ▪ 13 (100%) included one or more operational definitions of replacement behavior(s). However, of these, three included inadequate definitions for identified replacement behaviors (i.e., Individual #97, Individual #184, and Individual #140). As a result, 10 (77%) included adequate operational definitions for replacement behaviors; ▪ 13 (100%) included a purpose(s) of the plan, including proposed underlying function(s) of target behaviors; ▪ 13 (100%) included behavioral objectives for one or more target behaviors. However, of these, two included inadequate objectives for target behaviors (i.e., Individual #170 and Individual #245). As a result, only 11 (85%) included adequate behavioral objectives for target behaviors; ▪ 13 (100%) included behavioral objectives for one or more replacement behaviors. However, of these two included incomplete objectives (i.e., Individual #97 and Individual #271). Consequently, 11 (85%) included adequate behavioral objectives for replacement behaviors; ▪ 12 (92%) included baseline data for one or more target behavior(s). The exception was Individual #140; ▪ 10 (77%) included baseline data for one or more replacement behavior(s). The exceptions were Individual #140, Individual #245, and Individual #87; ▪ Five (38%) conspicuously identified the use (or not) of SAPs to formally address the acquisition of replacement or alternative behaviors. The exceptions were Individual #65, Individual #111, Individual #170, Individual #140, Individual #40, Individual #87, Individual #271, and Individual #240. Consequently, it was only clear in five (38%) of the sampled plans whether or not SAPs were in place to support the acquisition of needed replacement or alternative responses; ▪ 11 (85%) described potential establishing operations. The exceptions were PBSPs where these were missing and/or not conspicuously identified (i.e., Individual #140 and Individual #40); ▪ 13 (100%) included antecedent-based or preventative strategies; ▪ 13 (100%) included strategies to promote replacement or alternative behavior; ▪ 13 (100%) included consequence-based strategies or interventions aimed at weakening target behaviors; ▪ 13 (100%) appeared to include the use of positive reinforcement. Most of the PBSPs appeared to identify potentially robust individualized reinforcers; ▪ 13 (100%) included descriptions of data collection procedures; ▪ 13 (100%) included descriptions of plans to reduce the intensity of intervention(s). However, these descriptions appeared inadequate for the	

		majority of plans (i.e., Individual #184, Individual #65, Individual #111, Individual #140, Individual #40, Individual #97, Individual #271, and Individual #240). In many cases, the descriptions were unclear, too general or vague, or prescribed changes that appeared potentially more intrusive. Consequently, five (38%) included adequate descriptions of plans to reduce the intensity of the interventions; ▪ 13 (100%) included grade level readability estimates all below a 7.0 grade level; ▪ 13 (100%) included the formatting and directions for conducting competency-integrity checks; and ▪ 13 (100%) were signed and dated. Overall, consistent with findings from the Monitoring Team's previous report, the revised PBSP format continued to facilitate the development of plans that were similarly structured, included consistent content and remained relatively concise and user-friendly. For example, 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 presented in order and included the use of positive reinforcement (i.e., in most cases identifying individually identified reinforcers). Indeed, the quality of the PBSPs continued to improve. Nonetheless, a few areas of concern regarding their adequacy remained. For example, in several cases, operational definitions for target and/or replacement behaviors appeared inadequate. Minor text omissions (e.g., "… per week …") in several behavioral objectives were noted. These omissions were likely to limit interpretability of data and subsequent analysis. In addition, it was not always clear whether or not SAPs were in place to support the acquisition of replacement or alternative behaviors. It should be noted that, based on the provided Action Plan for Section K.9, the Facility had identified this as an issue and was working to make this conspicuous in PBSPs. And, as noted above, plans to reduce the intensity of interventions found in sampled PBSPs were often too general and/or unclear. It is important for the Facility to recognize, and note in PBSPs, as appropriate that, in some cases, the intensity of interventions as prescribed within PBSPs might not be readily reduced. That is, the interventions might not include strategies that are restrictive or artificial. Consequently, for some PBSPs, the reduction of the intensity of interventions might not be possible or feasible. 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, dated 12/12/13, were examined. Eight 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 eight individuals reflected 6% of total number (N=133) 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 were examined for each individual sampled. According to the dates provided, necessary consents were obtained prior to the implementation of the PBSP for approximately seven (88%) of those individuals sampled. More specifically, according to provided documentation, it appeared that the PBSP for Individual #140 was implemented on 1/10/13, prior to receipt of the guardian and Director's approval. In addition, of those sampled, eight (100%) PBSPs were implemented within 14 days of receiving necessary consent from the guardian or approval from the Director. Based on data reported on the current PBSP Master List, 129 (97%) of all active PBSPs met the 14-day criteria. This appeared accurate, because the recorded dates on sampled documents (noted above) matched dates identified in the summary listing. In addition, of those sampled, seven (88%) received necessary consents within 30 days of BSC approval. More specifically, it appeared that guardian consent was received in excess of 30 days following BSC approval of the PBSP for Individual #40. Overall, based on the current PBSP Master List, 120 (90%) received necessary consent within 30 days of BSC approval. It should be noted that HRC approval for the PBSP (as required) appeared to be appropriately received for Individual #40, but the evidence provided (i.e., information in a table) did not include the previously reviewed HRC form (including signature of the human rights officer). It was unclear to the Monitoring Team if the process and/or documentation utilized had changed or if previously viewed forms were missing. Progress in the development of quality PBSPs continued to be noted. However, a few remaining concerns were noted, as described above, and 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 operational definitions for replacement behaviors, ensure adequate behavioral objectives for target and replacement behaviors, conspicuously identify if SAPs are in place (or not) to teach replacement behaviors, and provide clarity and specification with regard to reducing the intensity of interventions, as applicable. 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	As previously discussed with regard to Section K.4 of the Settlement Agreement, a sample of 13 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., September, October, and November) were examined. Based on the PBSP Master List, dated 12/12/13, this sample of 13 individuals reflected 10% of total number (N=133) of individuals with active PBSPs. This review included the examination of the current PBSP as well as Monthly PBSP Progress Notes from September, October, and November 2013, as available. Currently, monthly PBSP Progress Notes were completed for 13 (100%) of the	Noncompliance

	maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	individuals sampled. At least one target behavior and at least one replacement behavior were adequately displayed in monthly PBSP progress notes for 10 (77%) of the individuals sampled. Adequate operational definitions for target and/or replacement behaviors were found on monthly PBSP progress notes for 11 (85%) of those sampled. In addition, target and replacement behaviors were consistent across the PBSP and monthly PBSP progress notes for seven (54%) of the individuals sampled. Monthly notes contained timely target and/or replacement behavior data for 11 (85%) of the individuals, and appeared to be completed in a timely fashion (within 30 days) for nine (69%) 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 (77%) 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 and utilized individual data paths for 13 (100%) of the notes reviewed. Indeed, 13 (100%) of the sampled individuals had graphs that were easily interpretable. This was aided by the use of more divergent data markers facilitating the interpretability of the graphs for all individuals sampled. However, 12 (92%) included both data on both target and replacement behavior(s). The exception was Individual #87. In addition, the continued inclusion of condition change lines or other demarcations on graphs to illustrate changes in programming or other variables, however, was only evident in nine (69%) of the individuals' monthly notes. The exceptions included Individual #140, Individual #87, Individual #271, and Individual #274, where these interpretive aids were not utilized. As presented with regard to Section K.4 of the Settlement Agreement, inclusion of monthly IOA estimates were found in at least one of the sampled monthly notes for 11 (85%) of the individuals sampled. Closer examination revealed that the inclusion of monthly IOA estimates was found in all three monthly notes for seven (54%) of the individuals sampled. It should be noted that the Monitoring Team determined the inclusion of IOA estimates within at least one as well as all three sampled monthly notes had remained consistent with previous reviews, and provided an estimate of adherence to expected practice. That is, the Facility's current prescription of one IOA probe for each PBSP per month provided important information. Overall, the increased consistency with regard to the inclusion of IOA in monthly notes appeared to reflect improvement in the quality of monthly PBSP progress notes. 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), 335 IOA probes in a subsequent six-month period (ending September 2012), and 1253 IOA probes between 11/1/12 and 5/31/13. Data reviewed in the Monitoring Team's last report indicated that an average of 71.7 IOA probes were conducted per month (with a range of 43 to 90 each month), from November 2012 through May 2013, with an estimated average agreement of 88.1% (range of 49.2% to 96%). At that time, the Facility reported that, on average, IOA probes were conducted on 53.4% of the total number of active PBSPs per month (with a range of 31.9% to 63.7% each month). Currently, based on data presented within the Section K Presentation Book, the Facility reported that 1540 IOA probes were completed between 5/1/13 and 11/30/13. During this time period, the Facility reported that an average of 220 IOA probes were conducted per month. Data provided within the Section K Self-Assessment (i.e., not including November data) evidenced an approximate range of 155 to 275 probes completed each month. It was reported that these probes generated an estimated average agreement of 91% (with an approximate range of 79% to 98%). These findings reflected a continued improvement in the completion of IOA probes over time. Indeed, summary data reflected an improvement (i.e., increasing trend) in estimated agreement scores over time. In their Section K.10 of their Self-Assessment as well as in the Section K Presentation Book, the Facility provided information to represent the effective use of documentation utilized to facilitate clinical review of medical conditions, including psychiatric treatment (i.e., use and impact of psychotropic medication). More specifically, the Facility provided examples of completed Quarterly Psychoactive Mediation Reviews as evidence of the Facility's integration of PBSP behavior data and other information (e.g., DISCUS and MOSES findings, lab results, etc.) when evaluating the effectiveness of psychotropic medication. In addition, the Facility outlined a quarterly review schedule for when these would be completed for each program across campus. In an effort to review the implementation of this system, a sample of Quarterly Psychoactive Mediation Reviews was examined. More specifically, a sample of 12 individuals who had an ISP meeting within the last six months and who also had PBSP were selected, and their most recent Quarterly Psychoactive Mediation Review as well as PBSP and Monthly PBSP Progress Notes were reviewed. Review of the sample revealed that 12 (100%) individuals had Quarterly Psychoactive Mediation Reviews completed since the Monitoring Team's last visit. In addition, behavior data was included in 12 (100%) of those sampled. However, the data provided only appeared consistent with the PSBP and Monthly PBSP Progress Notes for 10 (83%) of those sampled. That is, the data included in the quarterly review for Individual #271 and Individual #240 did not appear consistent with other documentation. More specifically, the data illustrated in the quarterly review for Individual #271 included targets (i.e., "good behavior game" and "functional communication") that were not defined in the PBSP and/or tracked on monthly PBSP notes. Similarly, data illustrated in the quarterly review for Individual #240 included targets (i.e., "SIB" and "suicidal threats") that were not defined in the PBSP and/or	

		tracked on monthly PBSP notes. It should be noted that, if these targets were changed concurrent with the recently revised PBSP, dated 12/10/13, these changes were not conspicuously described. Overall, provided documentation evidenced a system that was likely to permit clinical review of medical conditions, including psychiatric treatment (i.e., use of psychotropic medications). However, although the schedule for the anticipated completion of these quarterly reviews was provided, additional data (e.g., timeliness, quality, etc.) related to their actual completion was not provided. For example, although submitted, it was unclear why two of the sampled quarterly reviews (for Individual #184 and Individual #87) were not completed concurrent with the prescribed schedule. Consequently, provision of this additional information would evidence that this system was being utilized as intended. It should be noted that the Monitoring Team observed examples of the use of behavioral data, reflecting ongoing data-based decision-making, across several meetings during the onsite visit. More specifically, during the psychiatric clinic on 1/8/14, held at Tulip (i.e., for Individual #99, Individual #146, and Individual #299), graphed data was presented. In addition, during the BSC meeting on 1/9/13, behavioral data, including graphs, was presented and discussed with regard to review of the SFA and PBSP for Individual #264. Overall, improvement in the quality of ongoing documentation and monitoring, specifically with regard to the collection of IOA and integrity data was observed. However, consistent inclusion of this data as well as other critical elements within monthly notes, including graphic displays, was not evident in all sampled documents. To move in the direction of substantial compliance, the Facility should ensure that critical elements necessary for accurately evaluating treatment efficacy are included within monthly PBSP progress notes, including graphic displays.	
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.	The Monitoring Team's previous reports reflected increasing progress over time in the Facility's conversion of PBSPs into the most recently revised PBSP format. Indeed, at the time of the Monitoring Team's last report, the Facility indicated that 100% of current PBSPs had been revised consistent with the updated format. This claim was supported at that time by the Monitoring Team's finding that all of the PBSPs sampled were written in the most current format. In an effort to more closely examine the format of current PBSPs, a sample of 13 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 12/12/13, this sample of 13 individuals reflected 10% of total number (N=133) of individuals with active PBSPs. Similar to previous reviews, the Facility currently reported that 100% of PBSPs were completed in the streamlined format to facilitate staff readability and comprehension. Closer review of the sampled PBSPs revealed that 13 (100%) were completed using the most recent streamlined PBSP format. As previously noted, this format appeared likely to improve the accessibility, understanding, and implementation by staff. Sampled plans appeared similarly	Substantial Compliance

		structured, three to five pages in length (most were four or less pages), concise, and relatively user-friendly. As previously 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. The BSC reportedly monitored these readability levels, and, when necessary, they were re-written to meet this criterion. According to provided summary data (PBSP Master List, dated 12/12/13), 100% of the PBSPs (N=133) had readability levels below a 7.0 grade level, and analysis indicated an average reading level of 5.8 (range of 3.2 to 6.9). Currently, closer review of the sample of PBSPs revealed that 13 (100%) were scored at or below a 7.0 grade reading level. That is, the sampled PBSPs revealed an average grade reading level of 5.5 (with a range from 3.5 to 6.4). Overall, since the Monitoring Team's last visit, the Facility appeared to have maintained the progress noted in the Monitoring Team's previous report. As a result, PBSPs continued to be written so that direct support professionals could understand them effectively. Consequently, the Facility remained in substantial 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.	The Monitoring Team's previous reports described the nature of New Employee Orientation (NEO) and on-the-job-training (OJT), and, across reports, continued progress in developing, providing, and monitoring more robust trainings and systems had been noted. Currently, according to verbal reports from the Director of Competency Training and Development (CTD), since the Monitoring Team's last visit, substantial changes involving NEO and OJT had been initiated. More specifically, the training duration of NEO was extended from 14 to 15 days. This expansion was related to increases in content related to mealtime procedures and other training issues. The Facility also reportedly had increased emphasis on the integration of skills targeted by this training within residential programs as well. For example, following the training on mealtime procedures during NEO, subsequent observation in the home was prescribed to ensure adequate integrity. The duration of OJT was expanded as well. More specifically, the prescribed training window for new hires was extended from seven to ten days. This extension appeared in response to the increased content (e.g., active engagement, mealtime procedures, etc.) covered during the training. According to verbal reports from the Director of CTD, the increase in training was supported by CTD staff as well as additional OJT instructors that the Residence Coordinators selected and trained to provide competency-based training to new hires. This training was structured through the use of the OJT training book that, according to verbal reports, had been updated multiple times since the Monitoring Team's last visit. This book contained documents that outlined required training content as well as required signatures and dates as	Noncompliance

		evidence of completion. According to the Director of CTD, new hires were not considered "graduates" of NEO and OJT until each content area had been trained and CTD received evidence (signatures on each required document). As described below, CTD closely monitored each new hire's individual training record to ensure that all necessary trainings were completed. Lastly, the additional time allotted for training appeared likely to ensure that Behavioral Health Specialist and Behavioral Health Assistants had sufficient time to provide competency-based training of PBSPs to newly hired direct support professionals. It should be noted that this additional time has not appeared to negatively impact the number of plans trained per day. That is, according to the Director of Behavioral Services, the limit of three PBSPs trained per day during OJT was still in place. As described in the Monitoring Team's previous report, efforts to ensure the quality of competency-based trainings (CBT) by behavioral services staff included the revision of prescribed methods of CBT developed through collaboration between Texas Tech University and Behavioral Health Services. As previously described, these methods required, for example, 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, these methods appeared to be centered on trainee demonstration of skills, trainer performance feedback, and objective ratings (using competency-integrity checks) of trainee competency that were subsequently tracked (e.g., PBSP number, date, trainee names, and scores). Recent onsite direct observation of staff training (for the PBSP of Individual #155) evidenced the utilization of some of these prescribed methods. More specifically, two trainers were involved in training and provided the PBSP as well as data cards to participants. And, although the trainers provided a comprehensive review of the PBSP as well as practiced the use of the data cards, the method of training was generally didactic and focused more on participant verbal behavior than their actual demonstration of skills. Throughout the training, the instructors were more likely to ask "tell me _____" than "show me _____," with the exception of crisis intervention strategies (e.g., staff practiced blocking skills). Going forward, the training would be more effective if there were more opportunities for trainees to demonstrate actual responses prescribed within the plan (e.g., demonstrate the topography of target behaviors, practice coping skills, etc.), especially when trainers were assessing trainee competency. In addition, the training likely would have been more efficient and effective if the trainers had facilitated more group activities (e.g., practice skills with each other), rather than being assessed primarily one-on-one. The Monitoring Team's previous reports have evidenced the completion of substantial trainings for direct support professionals targeting PBSPs. That is, in the past, provided listings have evidenced trainings on PBSPs for new hires as well as current staff. For example, in the Monitoring Team's last report, data indicated that a total of 88 new hires were trained on PBSPs across 14 residential programs, and that a total of 209 current	

		staff received training on PBSPs (involving 62 PBSPs) across residential, day program, and vocational settings between November 2012 and April 2013. At that time, data on the PBSP Master List (dated 7/11/13) revealed that 97% of PBSPs were implemented following competency-based training. Currently, provided documentation evidenced a significant number of trainings on PBSPs between May and November 2013. More specifically, data indicated that a total of 938 trainings were conducted since the Monitoring Team's last visit, this included 33, 168, 161, 125, 192, 118, and 141 completed in May, June, July, August, September, October, and November 2013, respectively. Closer examination revealed that each training session was attended, on average, by two to three staff members and lasted just over 30 minutes. Data on the PBSP Master List (dated 12/12/13) revealed that 99% of PBSPs were implemented following competency-based training. As described in the Monitoring Team's previous reports, the Facility had implemented efforts to ensure and monitor the training of pulled staff using a process including the "Pull Staff Member Orientation Page." However, previous findings indicated that this system had been inconsistently utilized. In an effort to improve and ensure the consistent use of this process, including the completion of this document, a new policy titled the "Pulled Staff/Transfer Staff Process," dated 12/11/13, recently had been implemented. That is, according to verbal reports from the Director of CTD, Facility staff had been trained on the new policy. The policy outlined the process in which the Facility would facilitate adequate training of pulled staff. This process identified the Home Team Leader or Assistant Home Team Leader as responsible for providing competency-based training on the PBSPs of those individuals in the group to which the pulled staff was assigned, reviewing the level of support for those individuals, identifying any individuals who could not be restrained, reviewing data cards for those in the group, and reviewing the PNMP for those in the group. Indeed, there appeared to be a significant amount of information that a pulled staff was responsible for acquiring, especially given that it might be the first time the staff member was in the particular residence. The policy also prescribed procedures for the training of transfer staff by Behavioral Health Services and Habilitation Services staff. And, although procedures were in place to review the integrity with which documentation was adequately completed, it did not appear that the Facility had processes in place to estimate the quality of the training these individuals received. More specifically, it was unclear if the Facility had processes in place to ensure that the training was effective in preparing pulled staff to implement all of the required elements as described above. One way to ensure that this process was effective in preparing pulled or transfer staff to effectively work with assigned individuals would be to also complete competency-integrity checks on pulled and transfer staff. That is, a determined number of integrity checks could be completed on a sample of staff that was proportional to the number of pulled or transfer staff typically utilized in residential programs.	

		As noted in the Monitoring Team's previous report, in June 2013, the development of a new data management system had been initiated to manage and monitor trainings, including the training of new hires as well as other Facility staff. This included, for example, data corresponding to the training of PBSPs across all staff (e.g., regularly assigned as well as pulled staff). At that time, descriptions of the 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. Currently, it appeared that this system was functional, and could produce some individual training records for staff as well as individual PBSPs. For example, provided examples of print outs that reflected the system's ability to identify the names (and dates) of staff trained on a specific PBSP, trainings attended by a specific staff member, as well as the trainings completed by a specific trainer or within a specific program. However, verbal reports indicated that data was just being inputted into the database, and that ongoing efforts would be necessary to fully populate the database. Overall, the database appeared very promising in the effective monitoring of trainings on campus. This was an essential piece, however, because without it a determination could not be made that all staff had completed the necessary training. As presented with regard to Section K.4 of the Settlement Agreement, inclusion of monthly competency-integrity estimates was found in at least one of the sampled monthly notes for 13 (100%) of the individuals sampled. Closer examination revealed that the inclusion of competency integrity estimates was found in all three monthly notes for eight (73%) individuals. It should be noted that the Monitoring Team determined the inclusion of integrity data within at least one monthly note as well as in all three sampled monthly notes had remained consistent with previous reviews, and provided an estimate of adherence to expected practice. That is, the Facility's current prescription of one IOA probe for each PBSP per month provided important information. Overall, the increased consistency with regard to the inclusion of integrity estimates in monthly notes appeared to reflect improvement in the quality of monthly PBSP progress notes. As reported in the Monitoring Team's previous report, competency-integrity checks were completed by scoring items embedded within the most recently revised PBSP format. 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. Indeed, this was consistent with findings from the current review of sampled PBSPs. Consequently, it was likely that all PBSPs were developed within the format supporting competency-integrity checks. The Monitoring Team's previous reports reflected progress over time in the completion of competency-integrity checks. More specifically, previous summary data indicated that approximately 496 competency-integrity checks (across 15 residential sites) were completed between April 2012 and September 2012, and that 799 competency-integrity checks were conducted between 11/1/12 and 5/31/13. These checks produced an estimated average monthly integrity score of 94% (ranging between	

		92.4% to 96.5%), based on approximately 84.6%, on average, of active PBSPs per month (i.e., between November 2012 and May 2013). At that time, provided data reflected improvement over time in the number of competency-integrity checks completed, mean average scores, and in the percentage of PBSPs for which competency-integrity checks were completed. Currently, summary data included within the Facility's Section K Presentation Book for Section K.4 indicated that a total of 893 competency-integrity checks were conducted between May and November 2013. These checks produced an estimated monthly average integrity score of 97% (ranging between 96% to 99%) based on approximately 128 checks, on average, completed each month (ranging from 101 to 137). Although data was not specifically provided on the percentage of plans on which integrity checks were completed, it was assumed by the Monitoring Team that these scores closely adhered to the total number of PBSPs in place. Indeed, a provided spreadsheet ("PBSP Competency-Integrity Checks") listed data that appeared to reflect increases in the number of integrity checks completed for individuals with PBSPs. Consequently, it appeared likely that competency-integrity checks were completed for most, if not all, PBSPs each month from May through October 2013. Overall, efforts to enhance the provision of NEO and OJT to new hires were noted. In addition, the Facility appeared to conduct competency-based training for staff on the majority of PBSPs. Onsite observation suggested that the quality of the CBT of PBSPs could be more robust. However, given that Facility has just initiated the systems necessary to track and monitor that all direct support professionals and their supervisors successfully completed CBT on the overall purpose, objectives, and implementation of the specific PBSPs for which they are responsible, 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 closely monitor trainings conducted for all PBSPs.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the recent onsite visit, in addition to the Director and Assistant Director of Behavioral Health Services, LBSSLC employed nine other Behavioral Health Specialists. Of these 11 staff, six were currently BCBAs. In addition, LBSSLC currently employed seven Behavioral Health Assistants. Currently, there were no vacant positions in the Behavioral Health Services Department. As of 1/6/14, reports indicated that LBSSLC currently served 202 individuals. Based on this current census, and the recognition that the Director and Assistant Director did not carry formal caseloads, an approximate average ratio of 1:22 Behavioral Health Specialist-to-individual served was determined. With seven Behavioral Health Assistants	Noncompliance

		currently employed, the Facility exceeded the ratio of one Behavioral Health Assistant for every two Behavioral Health Specialists 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 Curricula Vitae of Medical Director, if new since the last visit; o Name and degrees of all Primary Care Providers that were new to the Facility since prior Monitoring Team's 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 International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) diagnostic criteria in last six months; o Since the last onsite review, copy of Continuing Medical Education (CME) for each Primary Care Provider, list of CME credits according to topics reviewed, list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since 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. Documents were submitted for the following: Individual #196 7/8/13 and 10/8/13, Individual #323 10/3/13 and 7/3/13, Individual #179 8/15/13 and 5/21/13, Individual #140 5/24/13 and 8/15/13, Individual #114 11/12/13 and 8/14/13, Individual #214 11/14/13 and 8/14/13, Individual #321 10/2/13 and 7/2/13, Individual #239 8/7/13 and 5/14/13, Individual #274 8/9/13 and 2/19/13, Individual #7 9/24/13 and 6/20/13, Individual #132 10/8/13 and 3/26/13, Individual #20 11/8/13 and 8/2/13, Individual #103 10/17/13 and 7/17/13, Individual #290 9/6/13 and 6/6/13 and Individual #192 5/1/13 and 2/1/13; 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, with separate reports/data of external medical peer review audits from internal medical peer review audits (i.e., both general medical and medical management audits), including information concerning the 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 Do Not Resuscitate (DNR), whether receiving hospice services, ambulatory status, and whether supplemental oxygen prescribed as part of routine care. Date of any Ethics committee meeting that reviewed the individual's terminal course, if applicable for the following: Individual #15, Individual #17, Individual #29, Individual #281, Individual #9, Individual #230, and Individual #78; 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 Monitoring Team's last visit which had follow up closure or action steps completed; o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of clinical/administrative death reports that remain incomplete/outstanding; o Nineteen most recent annual medical assessments and physical examinations and prior annual assessment and examinations for the following individuals: Individual #245, Individual #199, Individual #128, Individual #156, Individual #75, Individual #240, Individual #271, Individual #184, Individual #20, Individual #130, Individual #65, Individual #269, Individual #109, Individual #3, Individual #270, Individual #214, Individual #136, Individual #21, and Individual #139; o Specialty clinic schedule per month for the 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 other reasons 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 other reasons 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 List of individuals: a) with tracheostomies, b) with fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location), c) with injuries requiring visit to ER or hospitalization since the Monitoring Team's last onsite 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 onsite 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 (i.e., 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 (e.g., include calcium, Vitamin D, IV bisphosphonate, etc.), date of last Dual-energy x-ray absorptiometry (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 (e.g., 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 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations): Individual #273, Individual #233, Individual #125, Individual #4, Individual #213, Individual #6 9/17/13 and 9/21/13, Individual #225, Individual #258, and Individual #100; 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, IPN/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): Individual #76, Individual #135, Individual #284 9/19/13 and 9/14/13, Individual # 22, Individual #293, Individual #258, Individual #33, Individual #43, and Individual #283; o For these same 10 most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter, by category of infection for 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 (including the amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia, b) decubitus ulcers, c) UTIs, and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year, for individuals who have been newly diagnosed with: a) malignancy, b) cardiovascular disease, c) diabetes mellitus, d) sepsis, e) bowel obstruction or bowel perforation, and f) pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including name of individual, residence, 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): Individual #317, Individual #120, Individual #22, Individual #12, and Individual #313; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit, and the date of prior visit to the neurologist for these same individuals; o List of those with status epilepticus since the Monitoring Team's last visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged /new onset seizure since Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for 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, or Felbamate); o Any tracking of data for individuals who have transitioned to the community since Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post Move Monitor and Community Service Coordinator at 90-day transfer; o 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 (on campus and offsite), list of appointments that were completed and ones not completed (with reasons); o Number of individuals with VNS in place, date of placement, and date of replacement, if applicable; o For concerns identified needing closure at provider morning 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, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and IPN entries. Information submitted for the following individuals: Individual #58, Individual #103, Individual #170, Individual #79, and Individual #317; o Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; o ISPAs addressing missed appointments (i.e., mammograms, colonoscopies and off-site and onsite consultations) or refusals for the past three months; o List of missed medical appointments, with reasons, for the past six months; o Presentation Book for Section L; o 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 a 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 a list of monitoring/audit tools used and 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 a 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 the individuals' active record: the 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, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, and the past three medical quarterly reviews for the following individuals: Individual #258, Individual #323, Individual #43, Individual #309, Individual #55, Individual #283, Individual #184, and Individual #242; o Minutes of the provider morning meeting with handouts during the Monitoring Team's visit: 1/6/13 through 1/10/13; o Clinical Nutrition services policy 12/4/13 (R); o Copy of documents referencing timing of completion of quarterly medical reviews; o List of individuals with pica and number of incident each has had in the past year; o Copy of Medical Policy and Procedure Manual; o Additional offsite medical appointment data; o Respiratory distress evaluations for dysphagia and GERD in most recent 12 cases; and o Corrected Medical Department CPR dates of completion. ▪ **Interviews with**: o Glenn Shipley, DO, MPH, Medical Director; o Leah Shultz, RN, BSN, Medical Program Compliance Nurse; o Resurreccion Barranda, MD, Staff Physician; o Ricardo Rodriguez, MD, Staff Physician; and o Grazyna Thomas, PA-C, Staff Certified Physician Assistant. ▪ **Observations of**: o Individual #258, Individual #37, Individual #217, Individual #136, Individual #195, Individual #181, Individual #211, Individual #304, Individual #104, Individual #167, Individual #62, Individual #185, Individual #21, Individual #215, and Individual #250; o Neurology Clinic 1/8/14: Individual #312, Individual #225, Individual #309, Individual #120, Individual #213, Individual #30, and Individual #90; and o Provider Morning Meeting, on 1/8/13, and 1/9/13.
	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: internal and external medical provider quality assurance audits, internal and external medical management audits, and numerous quality clinical indicator-monitoring audits. o These monitoring/audit tools included some 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 focus on specific areas identified as needing improvement. 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: Medical Compliance RN, RN clinic manager, and PCPs. o Adequate inter-rater reliability reportedly had been established between the various Facility staff responsible for the completion of the medical management audit. Less information was provided concerning the medical provider quality assurance audit. The QA Department provided this information. As discussed with regard to Section L.3, there was considerable variability in the findings of the internal and external reviews, despite the fact that the same records were reviewed. This called into question the reliability of the results. ▪ The Facility used other relevant data sources and some key indicators/outcome measures 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. Examples of databases/data sources that were not considered included tracking response to abnormal test results, and clinical findings as part of change of health status. ▪ The Facility presented some 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 measure the quality as well as presence of items, such as annual medical assessments and quarterly medical assessments. ▪ The Facility rated itself as being in compliance with Sections 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 an analysis of the information, identifying for example the need for further in-service training for diabetes mellitus, and tracking of timeliness of quarterly medical reviews.
	Summary of Monitor's Assessment: For Section L, progress was evident in all subsections. Strengths in Section L included preventive care, with completion of screening procedures such as colonoscopies, pap smears, and DEXA scans in a timely manner. The Medical Department demonstrated prompt and thorough monitoring and follow-through of all acute care issues at the provider morning meeting. Appointments were tracked until completion of the visit. There were numerous quality indicator-monitoring tools created for specific diagnoses. Audit results were available. The Facility conducted analysis of results of various audits, completed in-service training, and conducted further audits to determine impact of the training. Follow-up on recommendations from the mortality review process appeared to be occurring, and closure of recommendations was now tracked. There were several challenges. The quality and timeliness of the annual medical assessments required further review, as well as the quality of the quarterly medical reviews. The internal quality improvement would benefit from focus on areas that remain challenging (e.g., evaluations of specific signs or symptoms such as respiratory distress, and monitoring of response to abnormal lab results). The medical manual

	required further development to reflect an ongoing review process.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and DNR orders. <u>Staffing and Administration</u> For the census of 202 individuals, as of the Monitoring Team's visit, there were three PCPs responsible for this population, along with the Medical Director. The Medical Director had a caseload of 16 individuals. Other PCPs had caseloads ranging from 60 to 67 individuals. There were no new PCPs since the Monitoring Team's last visit. There was no vacancy in the department. A list, dated 1/8/14, was submitted indicating those members of the Medical Department that remained current in CPR certification. Of the PCPs in the department, three of three and the Medical Director were current in CPR. Compliance with current CPR certification of these medical staff based on submitted documents was four of four (100%) physicians or physician extenders. Of the four PCPs in the Medical Department, a list of CME credits completed since the Monitoring Team's last visit was submitted for four of four. This varied from seven and one-half hours to 44 hours. The topics that were covered included: trauma, respiratory care for the critically ill patient, non-accidental trauma diagnosis, delirium management, non-invasive hemodynamic monitoring, genitourinary trauma, wound care, neck pain, obesity, safe opioid use, bites and stings, suicide, biomarkers of cardiovascular risk assessment and prevention, various pediatric topics/updates, and hospice and palliative medicine topics. The majority of the topics that were covered included areas of importance to primary care and the individuals residing at LBSSLC. There were no topics specific to intellectual or developmental disabilities. <u>Physician and Other Departmental Participation In Team Process</u> For the three provider morning meetings that occurred from 1/7/14 through 1/9/14 (1/8/14 and 1/9/14 meetings were observed), there was a signed attendance roster for three of three meetings. Departments represented at the provider morning meeting on a daily basis included: Medical Department (i.e., Medical Director, PCPs, and medical support staff), Psychiatry, Dental, Pharmacy, QIDP, Psychology, Hospital Liaison Nurse,	Noncompliance

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		PNMT/Habilitation services, and QA. Departments represented at the provider morning meeting on less than a daily basis included: RN Case Managers, and Infection Control. For the three provider morning meetings during the week of the Monitoring Team's onsite review, there were five hospitalizations discussed. Based on the Monitoring Team's observations and review of documentation: ▪ There were no new hospital admissions during the three-day time period. On 1/7/14, there were three individuals that returned to the Facility and two that remained hospitalized. ▪ For one of two hospitalized individuals, there were critical clinical questions raised followed by a request for the Hospital Liaison Nurse to follow-up with the medical team at the hospital. ▪ **Assignment of follow up concerns:** There were three critical clinical questions raised/identified as needing closure, which were followed by assignment to an IDT for ISPA (i.e., refused medication and refused specialty appointment repeatedly). ▪ **Assignment of open book/record review:** There were two assignments for hospitalized individuals requesting an open book review for the prior seven to 14 days of the illness to review monitoring of care, documentation, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation, need for consultation, review of medication and medication side effects, etc. There was one reassignment of a hospitalized individual with an overdue open record review report. ▪ For **previously assigned open book/chart reviews**, zero was presented during the three morning meetings. ▪ **Closure discussions**: There were two prior concerns with assignments for follow-up presented at the provider morning meetings. ▪ **Follow-up requested ISPAs reviewed:** There were two summaries of ISPAs that had been assigned to IDTs in responding to concerns referred by the provider morning meeting group. These were discussed and two of two were accepted as resolving/answering the concern. ▪ **Infection Control updates:** During the three provider morning meetings, there was one Infection Control update presented. ▪ **Summaries of completed consultations:** During the three provider morning meetings, there were 15 summaries presented of completed consultations, one for which a scheduling update was provided, and four consults that were not completed/did not occur. ▪ **Dental Department updates**: The Dental Department provided brief updates/information during one of three provider morning meetings.	

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		▪ **PT/OT/Speech Therapy (ST) and PNMT updates:** The PT, OT, ST, and PNMT presented updates during one of three provider morning meetings. ▪ **Skin integrity updates:** Skin integrity reports/updates were provided at zero of three provider morning meetings. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at one of three provider morning meetings (i.e., six individuals were discussed). ▪ **Hospital Liaison Nurse updates:** The Hospital Nurse Liaison reported an update at three of three provider morning meetings. ▪ **On-call PCP participation:** For the three provider morning meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in three of three meetings. The strengths noted at the provider morning meeting included the following: the meeting followed a structured format and included all areas of acute illness/change of status on campus, as well as follow-through on hospitalizations, consults, and closure concerns, including tracking open record reviews and ISPAs. Attendance included all clinical departments on a regular basis. There were three good examples of interdisciplinary discussion at the observed meetings (i.e., one ISPA, one individual hospitalized, and one individual that was listed on the Campus Coordinator Log). Tracking of concerns was followed until evidence of closure was submitted. Meeting minutes were brief, and major areas (i.e., ISPA tracking, open record reviews, and other closure concerns) were placed in chart format. There were no weakness or concerns identified. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted for the prior year. The document, dated 12/16/13, listed 206 individuals. Eight individuals, newly admitted after 12/16/12, were omitted, because they had no prior dates of annual assessments. For the remaining 198 individuals, annual assessment dates were then compared to the prior dates. The information was considered adequate for analysis of timeliness. There was no individual for whom information was lacking or that suggested a typographical error or data entry error. For 198 individuals, there were dates of prior and current annual medical assessments listed. One hundred forty of 198 (71%) of the recent annual medical assessments were completed within 365 days of the prior assessment. For 19 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. Timeliness was determined if the	

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		most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. ▪ For the submitted annual medical assessments, compliance was 15 of 19 (79%). ▪ For the 19 most recent annual medical assessments, there was an interval history included as part of the document in 19 of 19 (100%) reviews. ▪ For the 19 most recent annual medical assessments, plans of care addressed each of the significant current diagnoses in 19 of 19 (100%) assessments. ▪ For the 19 most recent annual medical assessments, 19 of 19 (100%) addressed smoking history. ▪ Family history was adequate/helpful in four annual medical assessments. For one, there was a statement regarding the reason for not having adequate family history (i.e., adoption). For 10, the information was listed as unknown or unavailable. For four, the information was considered incomplete. Of the 18 for whom an adequate family history would be expected (the adopted individual was removed in calculating family history compliance), four of 18 (22%) annual medical assessments included family history. ▪ A discussion of readiness/requirements for transition to the community was included in 19 of 19 (100%) annual medical assessments. As part of the monitoring review process, the Monitoring Team selected the medical records of eight individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on identifying individuals with various diagnoses/health care issues, and selecting a sample of individuals from each category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This sample was done to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included preventive care flow sheet, physician orders for the prior one-year, IPNs for the prior one-year, the most recent three quarterly medical reviews, the most recent PBSP, 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 IRRF, 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 most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From eight medical records reviewed: ▪ Eight of eight (100%) annual medical assessments had been completed in the	

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		prior 365 days. ▪ Active problem lists appeared to be thorough in six of eight (75%). ▪ Eight of eight (100%) annual medical assessments included information concerning a smoking history and/or substance abuse history. ▪ A family history was documented (or attempts at obtaining this information) in three of eight (38%) records. There were three additional records with a brief/limited family history that was incomplete. Two records had no information. ▪ Eight of eight (100%) had information discussing requirements for transition. For the annual medical assessments, there were discrepancies in content that needed further explanation or correction. One individual had "Diet: NPO all meds per tube. Jevity 1.5 and water supplements per pump" and under "Discussion of Significant Problems: Oropharyngeal dysphagia mild. On ground diet texture and nectar thick fluids… Gastroparesis: on… six small meals." The Medication Administration Record (MAR), the pharmacy patient profile, and the 90-day Medication Orders stated: "Nectar consistency diet texture ground." The 90-day medication review stated: "NPO. Peptamen 1.5 with prebio at 75ml/hr and water flushes." On 4/25/13, there was also discussion of pleasure feedings, but it was difficult to determine any implementation phase. It would appear that the record needed to be reviewed by the Medical, Pharmacy, and Nursing Departments to ensure consistency and clarity of information. Given that various departments had several quarterly assessments and/or monitoring programs place, these significant discrepancies should have been corrected and clarified. For another individual, the annual medical assessment had inconsistent or incomplete information when discussing procedures. The annual medical assessment listed a colonoscopy as being completed on 9/7/12. The Active Problem List included colonoscopy results of 2004 and 2009. The "significant diagnostic procedures" listed colonoscopies on 12/17/07 and 9/7/12. For DEXA scans, the annual medical assessment under x-rays listed a DEXA completion date of 5/9/13, the Active Problem List documented a DEXA on 1/11/11, and the significant diagnostic procedures listed dates of 1/6/11, 5/9/12, and 5/9/13. It would be helpful to list the dates of historical procedures in one section, with significant findings. It might also highlight discrepancies (e.g., DEXA completed on 1/6/11 and 1/11/11). The reason for frequent DEXA scans could not be determined. Another individual had been fed via PEG tube since 7/23/13, having aspirated all consistencies according to a Modified Barium Swallow Study. The printed "90-day review Day Medication Orders" from 10/2/13 through 1/2/14 listed "nectar thickened fluids diet texture pureed." The 90-day Medication Review of 10/2/13 listed "NPO, Jevity…" On 12/18/13, an updated dietary recommendation was ordered with a change	

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		in tube feeding rate. The inconsistency in documentation needed to be reviewed for all of this individual's records. It did not appear that the Pharmacy Department reviewed and updated the information on preprinted orders. The PCP, however, signed the orders, which included "nectar thickened fluids diet texture pureed." If the individual was NPO and staff did not know that information, and saw the orders for nectar thickened fluids and pureed texture, the staff might attempt to feed the individual by mouth, creating an unsafe situation. Given these findings, it is recommended that the diet orders be reviewed and corrected for all individuals, and steps be taken to ensure consistency of information across documents. Staff should have correct instructions on an individual's diet at all times. It is recommended that a Medical QI process be implemented to address this concern campus-wide, and that such monitoring be integrated into ongoing quality assurance processes. A new template from the State Office for the annual medical assessment was discussed at the Medical Department Meeting of 9/18/13. These eight medical records also were reviewed to determine whether the physician IPN note used the SOAP format for acute illness documentation. For each record, acute illness documentation was reviewed for three PCP IPN entries, for a total of 24 IPNs. ▪ In 24 of 24 (100%), the SOAP format was used. ▪ In 24 of 24 (100%), the SOAP IPNs included the date. ▪ In 24 of 24 (100%), the SOAP IPNs included the time. ▪ In 22 of 24 (92%), the SOAP IPNs recorded vital signs or referenced vital signs from a prior entry from the same day. In a document entitled: "MD Quarterly Dates (last updated 12/16/13)," the Medical Department provided a list of quarterly medical reviews that were completed each quarter for all individuals. Information for 203 individuals was provided. Four individuals were new admissions, and one individual might have been placed outside of LBSSLC for a period of time and quarterly medical reviews were not available except the last two. The information for three quarterlies was reviewed for each of the remaining 198 individuals to determine compliance with timely completion. There were 12 quarterly medical reviews from Residence #514 and one quarterly from Residence #516 for which dates were not provided and were considered overdue. Based on submitted information for these 198 individuals, for two quarters, the compliance rate for completion within the month of the following quarter was 93 percent (185 of 198). It was noted that this calculation did not account for those that were no longer at the Facility due to transfer, transition, or those who might have been admitted in the prior six months, etc. Moreover, it is important to note that the month in which the quarterlies	

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		were due for each specific home was not identified in the document. A calendar of the month in which they were due in each building (because it appeared that each home was assigned a specific three-month cycle for completion, such as January to April, July-October, February to May, August to November, etc.), would have allowed the dates to be matched to the due date for that month to ensure the quarterlies in the home were in compliance with the assigned month. Compliance was credited based on the information in this document that tracked completion of the quarterlies every three months. Again, the months assigned for completion per home were not identified in the document. However, the Monitoring Team's use of two different sampling methodologies did not verify compliance. A review of quarterlies based on review of submitted documentation of eight medical records, and a separate sample of quarterlies submitted for 15 individuals revealed gaps in timeliness. The Medical Department tracked the status of medical quarterly reviews. At the Medical Department meeting of 11/15/13, the Medical Director reviewed the timeliness of completion of these documents. A review of the eight medical records indicated a quarterly medical review had been completed in the prior three months in six of eight (75%). For the past nine months, quarterly medical reviews were completed per quarter in five of eight (63%). Contents of the quarterly medical reviews of 15 individuals were reviewed for timeliness and completeness. The two most recently completed quarterly medical reviews were submitted for each individual. A total of 30 quarterly medical reviews were submitted. Using a cut-off date of 11/25/13 (date of scan), for the most recent quarterly medical review submitted, 12 of 15 (80%) were timely in completion. Additionally, for one individual, the time between quarterlies was six and one half months. Thirty quarterly medical reviews were assessed for content with the following findings: ▪ A template format was used/completed in 30 of 30 quarterly medical reviews. ▪ In 30 of 30 (100%), the date of the quarterly review completion was included. ▪ In 30 of 30 (100%), the PCP completing the document was identified. ▪ In 27 of 30 (90%), the PCP initials/signature was included. ▪ Major diagnoses were listed in 30 of 30 (100%) medical quarterly reviews. ▪ The last three monthly weights or equivalent information were recorded in 29 of 30 (97%) medical quarterly reviews. However, the information provided was problematic for three individuals. For one individual, there appeared to be a data entry error as the change of weight was recorded as 100 pounds. Two other individuals appeared to have significant weight loss, but there was no comment noted by the PCP concerning this information (i.e., reason, plan, etc.), or alternatively a reference to an IPN (with date of IPN) discussing the	

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		evaluation and plan. ▪ There were brief comments/entries listing numbers of seizures per quarter (if applicable) in 22 medical quarterly reviews. For one individual, information was inaccurate. The individual had been hospitalized for aspiration pneumonia and seizures, yet the PCP recorded there was no seizure for that quarter. That same quarterly report indicated there were no pneumonias that quarter despite the hospitalization for aspiration pneumonia. ▪ There was documentation of changes in medication in 21 medical quarterly reviews. ▪ Important/abnormal labs and drug levels/radiographic test results were documented in 20 medical quarterly reviews. In the quarterly information, one record included old procedure reports and consultations, which was repeated in the next quarterly report, along with other studies completed during that quarter. ▪ Seven medical quarterly reviews had documentation of an ER visit. o Seven of seven (100%) included reasons for the ER visit. o Three of seven (43%) included treatment provided in the ER. ▪ Five medical quarterly reviews had documentation of hospitalization. o Five of five (100%) included reasons for the hospitalization. o Two of five (40%) included treatment during the hospitalization. ▪ Twenty-six medical quarterly reviews had documentation of consultations completed, listing the specialty. o Twenty-six of 26 (100%) medical quarterly reviews had documentation of consultation results. It was noted there was documentation of some events or reports in prior quarters, rather than focusing on updated information for the quarter in review. Under the ER section for that quarter was an ER entry from a prior quarter and for the same individual (i.e., Individual #214), under the hospitalization section was an entry from a hospitalization in 2012. It is recommended that the quarterly medical reviews focus on updated information for the current quarter reviewed. Additionally, a QA monitoring process focusing on the content of quarterly reviews would assist in reducing entry discrepancies concerning several clinical areas (i.e., accurate documentation of seizure occurrence, pneumonia occurrence, accuracy of weight entries, response to actual weight change, etc.). From the submitted sample of quarterly medical reviews, the timeliness and quality of content indicated a need for improvement. <u>Access to Specialists</u> Based on data the Facility submitted in a document entitled: "Off Campus Medical	

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		Appointment Schedule by Specialty (for May 15, 2013 to November 15, 2013)," the following chart indicates the offsite appointments scheduled, the offsite appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments. This document did not provide the number of initial visits, but this information was submitted in response to a subsequent document request in a document entitled: "Additional offsite medical appointment data." Differences in data by specialty have been asterisked. It is recommended the Medical Department compare these two documents for resolution of discrepancies. For some specialties listed, the number of appointments recorded as completed exceeded the total original appointments. This might have been due to differences in how appointments were tabulated. For instance, removal of rescheduled appointments due to specialty offices rescheduling the appointment (reasons over which LBSSLC would have no control) might have been reflected in one report and not the other. For the first reference, whether the appointment was an initial or follow-up to an initial did not appear to be distinguished. For others marked NR (Not Recorded) below, there was no information from the second reference, but the first reference recorded these appointments. Consequently, the total number of appointments made and completed might not be accurate, because several specialty appointments were not included in the totals. The Monitoring Team member found other inconsistencies. As an example, for the allergy specialty appointment, the "Initial Report Specialty Appointment" listed one of three appointments completed at the first visit, but the "Specialty Appointment Statistics" review indicated two appointments were completed at the first visit. The following represents the data the Medical Department provided. Progress had been made in determining completion rates for a number of specialties: | Specialty	Initial appoint-ment scheduled	Initial appoint-ment completed	Percent completion at first appointment	Follow-up initial appoint-ment completed	Percent completion or order discon-tinued** | |---|---|---|---|---|---| | Allergy | 3 | 1 | 33% | 2 | 100% | | Allergy & Asthma* | NR | NR | | | | | Cardiology* | 56 | 40 | 71% | 15 | 98% | | Dermatology* | 9 | 5 | 56% | 4 | 100% | | ENT* | 3 | 2 | 67% | 1 | 100% | | Gastro-enterology* | 100 | 83 | 83% | 14 | 97% | | General | NR | NR | | | |	

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Surgery*					
Hematology*	19	13	68%	2	79%
Hospital procedure	27	19	70%	6	93%
Internal Medicine*	NR	NR			
Nephrology*	4	2	50%	2	100%
Ophthal-mology*	4	2	50%	2	100%
Neurology*	10	7	70%	3	100%
Neurosurgery*	NR	NR			
Oncology*	2	1	50%	1	100%
Orthopedics*	2	1	50%	1	100%
Podiatry*	NR	NR			
Pulmonology*	16	11	69%	5	100%
Radiology*	121	89	74%	27	96%
Rheumatology *	NR	NR			
Sleep Study*	NR	NR			
Urology*	23	15	65%	4	83%
Wound Care*	4	3	75%	1	100%

**Due to transition to community, death, or other reason determined by PCP or IDT.

From a document entitled: "Cancelled Appointments by Home (listed per month May 1 – November 15, 2013)" reasons for the cancelled appointments/missed appointments were provided. The reasons included the following:

Cause of cancellation	Number of appointments cancelled	Cause of cancellation	Number of appointments cancelled
Medical illness	17	Specialist office	37
No consent	27	Conflict in schedule	10
Nursing services	4	Refused/behaviors	17
Other	28	**Total**	**140**

Follow-up of the 140 missed appointments indicated that 82 appointments were subsequently rescheduled and completed. Thirteen individuals did not need to be rescheduled, based on PCP or specialist recommendations. Other categories of reasons included lack of consent from family/guardian, rescheduled with appointment pending, and not rescheduled with no reason listed.

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		Onsite, specialty clinics were held to meet the needs of the individuals for the six months prior to the Monitoring Team's visit. The following chart provides details of these specialty clinics:	

Specialty	Date of clinic	Scheduled	Com-pleted	Re-scheduled	Missed appoint-ment completed	Out-standing
Endocrinology	5/30/13	19	18	1	0	1
Endocrinology	6/27/13	20	19	1	0	1
Endocrinology	7/31/13	18	18	NA	NA	NA
Endocrinology	8/29/13	23	23	NA	NA	NA
Endocrinology	9/25/13	19	17	2	0	2
Vision	5/3/13	15	9	6	6	0
Vision	6/7/13	14	12	2	1	1
Vision	7/12/13	19	15	4	3	1
Vision	8/2/13	23	22	1	0	1
Vision	9/6/13	25	19	6	3	3
Vision	10/25/13	23	15	8	2	6
Podiatry	5/22/13	15	13	2	0	2
Podiatry	6/26/13	12	9	3	3	0
Podiatry	7/24/13	12	9	3	3	0
Podiatry	8/21/13	18	17	1	1	0
Podiatry	9/18/13	8	8	NA	NA	NA
Podiatry	10/23/13	15	11	3 of 4	1	3
Neurology	5/15/13	14	13	1	1	0
Neurology	6/5/13	11	10	1	1	0
Neurology	6/20/13	11	9	2	1	1
Neurology	6/28/13	12	7	5	4	0**
Neurology	7/10/13	12	10	2	0	2
Neurology	7/24/13	16	7	9	*	*
Neurology	7/26/13	10	9	0**	NA	NA
Neurology	8/7/13	14	13	1	0	1
Neurology	8/23/13	9	9	NA	NA	NA
Neurology	9/4/13	16	11	5	3	1**
Neurology	9/27/13	9	7	2	2	0
Neurology	10/9/13	13	10	3	0	3
Neurology	10/23/13	10	8	2	0	2
Total		455	377	78	At least	Data

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completion rate for initial and follow-up calculated as 91 percent			(83% show rate)	missed/ 76 re-scheduled	35 although data incomplete	incomplete	

*Second page appeared to be missing and numbers could not be determined, data incomplete for last two columns.
**A subsequent no show for one individual was followed by a pro re nata (i.e., as needed) (PRN) need for an appointment

The quality of the consultation referrals was reviewed as part of the peer review process. This is discussed in further detail with regard to Section L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed with regard to Section G2.

<u>Preventive Care</u>

- Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in eight of eight (100%) records reviewed.
- Preventive care flow sheets had been updated at the time of the annual medical assessment, or more recently, in eight of eight (100%) records reviewed.
- Current vision screening was documented within the prior 12 months in six of eight (75%) of the records reviewed, and in eight of eight (100%) within the prior 24 months.
- Documentation of audiological screening in the prior year was submitted in zero of eight (0%) records reviewed, and in the prior two years in one (13%) of records reviewed. No information was submitted for seven of eight. It was noted that the preventive care flow sheet form no longer included audiological screening dates, which had been part of the form in earlier editions. Audiological screening also was not noted in the annual medical assessment or in the submitted nursing quarterly/annual assessments that were reviewed.
- The influenza vaccination had been given to seven of eight (88%) individuals (88%) in a timely manner during 2013. For one individual, there was no recording of influenza administration on the preventive care flow chart, in a physician order, or IPN entry from October through December 2013, or in the nursing assessment for December 2013. The influenza vaccination had been given to eight of eight individuals (100%) in 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 eight of eight (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

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		indicated (or being tracked for completion), was recorded in eight of eight (100%) active records reviewed. ▪ A Tdap had been given to eight of eight (100%) individuals. For one record, there was a discrepancy in documentation of the actual immunization administered (i.e., whether Tdap or Td). The preventive care flow sheet indicated Tdap was administered on 5/7/12, but the annual medical assessment indicated a Td had been given on 5/7/12. If the annual medical assessment were followed, the individual would be recommended for a Tdap, when it had already been given according to the preventive care flow sheet. If the preventive care flow sheet were followed, the individual would not need another Tdap, although it might not have been administered, according to the annual medical assessment. It is recommended that the records of individuals be reviewed to ensure that Tdap was administered and documented rather than a tetanus vaccine without a pertussis vaccine component. ▪ A pneumococcal vaccination had been given to eight of eight (100%) individuals. ▪ For individuals age 60 or over, a zoster vaccine had been given to two or four (50%) individuals. *Mammograms* A list was submitted indicating women residing at LBSSLC, age of 40 to 70, along with the date of last mammogram, and the reason, if it was not done or outdated. The DADS SSLC policy "Preventive Health Care Guidelines," dated 8/30/11 was to be followed (i.e., annual screening between ages 40 and 70). A total of 37 women were identified as being over the age of 40. Of these listed, there were no women aged 70 or greater. Of the 37 women between the ages of 40 and 70, 11 had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 26 women, 23 had mammograms within the prior year. One individual had one scheduled in December 2013, but it would have occurred after the 12/16/13 scanning date. However, that individual completed a mammogram the prior year during December, and was current. There were two individuals that were unsuccessful in completing a mammogram in 2013, and remained overdue. There was no information concerning whether the IDTs had met to determine a plan, or whether another appointment had been scheduled for a mammogram. Compliance rate for the annual completion of a mammogram was 24 of 26 (92%). From the sample of eight medical record reviews, there were four females between the ages of 40 and 70. Of these, four females were eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Four of four (100%) were up-to-date on mammogram testing. *Gynecologic screening*	

#	Provision	Assessment of Status	Compliance
		From the sample of eight active records reviewed, there were four females between the ages of 21 and 65. ▪ Zero of four females had documentation of reasons for not completing cervical cancer screening within the prior three or five years. ▪ Of the remaining females, four of four (100%) females had documentation of cervical cancer screening within the recommended three to five years prior. The Facility submitted a document entitled "Pap Smear Tracking Women age 21 - 65 years old." Additional information was provided as evidence of testing on each of the listed individuals. The list totaled 44 women. Of these, six had a prior hysterectomy and were removed from the list of women eligible for cervical cancer screening. It was noted the Medical Department had not determined the reason for the hysterectomy for three of the six that had a hysterectomy. Of the remaining 38 women, 33 had a completed adequate pap smear reading, one had a pap smear reading pending, and one had an inadequate pap smear reading, but was rescheduled at the next annual examination for a repeat testing. Completion of adequate pap smear screening was 33 of 38. Compliance of adequate pap smear screening, pending results, or ongoing planned surveillance was 35 of 38 (92%). There were three individuals that had not had a pap smear and continued plans for completion were not provided. One individual had refused twice, and there was no information indicating referral to the IDT for resolution, need for a change in behavioral supports, or evidence of rescheduling. Two individuals had inadequate pap smear specimens, but the testing had not been rescheduled. *Preventive screening: 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 (i.e., screen or diagnostic testing for signs and symptoms). A total of 90 names were submitted. Of these, two were over the age of 75. It was noted that there was no incomplete data or data entry irregularities. As it takes time to schedule appointments and procedures, have IDTs discuss procedures and potential complications of the prep involved, and obtain consent from the family or guardian, individuals at age 50, who had not completed a colonoscopy, were removed from the list of those for whom a completed colonoscopy would be expected. There were seven individuals that were age 50, according to the submitted documentation. Of these, four had completed a colonoscopy. One was scheduled to see the gastroenterologist as a preliminary step in scheduling a colonoscopy. Two individuals had been scheduled for a colonoscopy: one refused and had been rescheduled, and one had an attempted colonoscopy, but due to inadequate effect of the bowel preparation, it was rescheduled. Due to these individuals being age 50, they were removed from the list of 90, as compliance of completion of a colonoscopy would be expected by age 51. Additionally, six individuals had clinical contraindications or family/guardian refusals of consent. One individual had a temporary clinical condition	

#	Provision	Assessment of Status	Compliance
		that required resolution prior to scheduling a colonoscopy. Therefore, the eligible population was 90 minus two (age), minus three (at age 50), minus six (clinical contraindications), and minus one (temporary clinical condition required resolution), resulting in 78 individuals. Of these, 74 completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Of the four individuals age 51 or older for whom a colonoscopy or clinical alternative was indicated, two provided evidence of prior attempts at colonoscopy with ongoing follow-up by the gastroenterologist, or had been scheduled for repeat colonoscopy. In summary, the rate for colonoscopy completion was 74 of 78. The rate of compliance for colonoscopy completion or ongoing surveillance and attempts at completion was 76 of 78 (97%). Of the eight active records reviewed, there were six individuals from the age of 50 to 75. One of these was currently age 50, and would not necessarily have had a colonoscopy completed at the time of the active record review. It was noted that this individual had been scheduled for colonoscopy the week of the Monitoring Team's visit. None were over the age of 75. Of the five remaining, zero had a clinical reason for not pursuing a colonoscopy. Of the remaining individuals for whom colonoscopy screening was indicated, five of five (100%) had a colonoscopy completed in the past 10 years. *Osteopenia/Osteoporosis* A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications (including calcium and Vitamin D) and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T-score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T-score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T-scores are indicated at intervals (every two to three years) to determine effectiveness of treatment. A total of 53 individuals had a diagnosis of osteopenia. ▪ Fifty-three of 53 (100%) DEXA scans were considered current (completed within the prior three years). ▪ Fifty-three of 53 (100%) had T-scores in the range consistent with osteopenia (between -1.0 and -2.5). For one individual, there was a typographical error. The Facility provided supporting documentation, which verified the individual had osteopenia. ▪ Fifty of 53 were treated with a bisphosphonate. It was noted that 15 of 50 were treated with a dosage indicated for osteoporosis rather than osteopenia, although information was not available to determine if the individual had a prior	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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diagnosis of osteoporosis with clinical improvement on pharmacologic treatment. The Medical Department is encouraged to review dosages of the bisphosphonates to ensure the appropriate dosage based on the clinical history and clinical indications specific to the individual.
▪ Two of 53 were treated with Calcitonin. The Medical Department is encouraged to review usage of this medication for these individuals, based on indications and risks of the medication, and based on the clinical history and clinical indications specific to the individual.
▪ One individual was on no bisphosphonate or alternative medication to treat osteopenia.
▪ Fifty-three of 53 (100%) listed the daily amount of calcium available in the prescribed/offered diet.
▪ Zero of 53 (0%) listed the daily amount of Vitamin D available in the prescribed/offered diet.
▪ Thirty-two of 53 were prescribed additional calcium supplementation.
▪ Forty-six of 53 were prescribed additional Vitamin D supplementation. The Medical Department is encouraged to review and monitor the prescribing of calcium and Vitamin D supplementation to ensure the optimal daily requirements are met, based on the amount of these nutrients offered in the diet, as well as the amount of calcium and Vitamin D available in any multivitamin that was additionally ordered.

Secondary causes for osteopenia were listed for the 53 individuals with this diagnosis. Causes were listed as follows (some individuals had more than one cause listed):

<table>
<tr><th>Secondary Cause</th><th>Number of Individuals</th><th>Secondary Cause</th><th>Number of Individuals</th></tr>
<tr><td>Medications</td><td>43</td><td>Vitamin D deficiency</td><td>2</td></tr>
<tr><td>Immobility</td><td>10</td><td>Hormonal deficiency or excess conditions</td><td>4</td></tr>
<tr><td>Unknown cause</td><td>9</td><td></td><td></td></tr>
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A total of 68 individuals had a diagnosis of osteoporosis.
▪ Of the 68 individuals with osteoporosis, four had contraindications or clinical reasons (i.e., lack of consent, inability to obtain adequate positioning for completion of the study, etc.) for not documenting a T-score. Of the 64 remaining eligible individuals, 63 of 64 (98%) were considered current (completed within the prior three years). There was one individual in which the most recent DEXA scan was prior to December 2010 (three years).
o Forty-three of 68 were treated with a bisphosphonate
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#	Provision	Assessment of Status	Compliance
		o Seventeen of 68 were treated with Calcitonin. The Medical Department is encouraged to review usage of this medication for these individuals, based on indications and risks of the medication, and based on the clinical history and clinical indications specific to the individual. o Thirteen of 68 were prescribed Prolia. o Six individuals were prescribed more than one medication to treat osteoporosis. o One individual was on no bisphosphonate or alternative medication to treat osteoporosis. o It appeared that six individuals were to be treated with osteoporosis medication pending dental clearance. For one pending dental clearance, the date the Reclast order was written was 5/1/12. This individual had not been cleared as of the date of submitted information. The Facility is encouraged to track dental clearances for timely completion to ensure medications to treat osteoporosis are administered in a timely manner. o Sixty-eight of 68 (100%) recorded the daily amount of calcium available in the prescribed/offered diet. o Four of 68 (6%) recorded the daily amount of Vitamin D available in the prescribed/offered diet. o Fifty-four of 68 were prescribed additional calcium supplementation. o Sixty-four of 68 were prescribed additional Vitamin D supplementation. The Medical Department is encouraged to review and monitor the prescribing of calcium and Vitamin D supplementation to ensure the optimal daily requirements are met, based on the amount of these nutrients offered in the diet, as well as the amount of calcium and Vitamin D available in any multivitamin that was additionally ordered. A review of 20 Nutrition Service Annual Assessments was completed to determine whether or not information was included concerning the daily intake of calcium and vitamin D in the diet, as well as supplements (i.e., vitamins, etc.). The Monitoring Team calculated the total daily intake for these nutrients based on the information provided in the assessments, and then compared the results to the Facility's Dieticians' calculations as summarized in the assessments. Agreement of calculations occurred in four of 20 (20%). The Nutritional Services Department is encouraged to review the steps used in calculating total daily intake of these nutrients. Secondary causes were listed for the 68 individuals with a diagnosis of osteoporosis. Causes were listed as follows (some individuals had more than one cause listed): | Secondary Cause | Number of Individuals | Secondary Cause | Number of Individuals |	

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Medication	48	Vitamin D deficiency	11
Immobility	40	Hormonal deficiency or excess conditions	10
Chronic renal disease	2	Unknown causes	9

From the sample of eight medical records reviewed, seven had a diagnosis of osteopenia or osteoporosis.

- Seven of seven had completed a DEXA scan.
- Six of seven (86%) of these DEXA scans were completed in the prior three years.
- Of these, seven of seven (100%) had a DEXA scan/T-score recorded.
- Of these, seven of seven (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia.
- Of these, five of seven had been prescribed supplemental calcium.
- Of these, seven of seven had been prescribed supplemental vitamin D.
- Of these, four of seven had a bisphosphonate ordered at the time of the Monitoring Team's visit.
- Additionally, there appeared to be time delays in dental clearance of Reclast administration. One individual had been waiting for clearance since 10/30/13. One individual was referred on 1/27/11, and was found not to be a candidate for Reclast when undergoing dental clearance on 9/17/12 (20 months later). (The annual medical assessment continued to indicate that clearance was pending, although the individual had an earlier dental exam denying clearance).
- Of these, two of seven had Miacalcin prescribed.
- Of these, one of seven had Prolia prescribed.

At the 9/18/13 Medical Department meeting, an update was provided for those individuals needing preventive screening, as well as current data on compliance in completing mammograms, colonoscopies, DEXA scans, and pap smears. At the 11/6/13 Medical Department meeting, the Medical Director reviewed the results of recent data concerning timely completion of DEXA scans, pap smears, and mammograms. Individuals not current in the preventive screening tests were reviewed as a quality improvement process. This was positive, and appeared to have assisted with improving and/or maintaining compliance rates.

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 four individuals were identified with a diagnosis of Down Syndrome. As of 11/25/13, four of four (100%) had a thyroid test completed within the prior 12 months.

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Acute and Emergency Care

The Medical Department tracked ER visits. The following data represents two months of complete information from July through September 2013. Documentation was provided for Emergency Room visits from July 1, 2013 through September 30, 2013. The following table lists this raw data by month, the number of emergency room visits for the month, and the most frequent/common categories of diagnosis for the visits, based on the submitted documentation:

Month	Admiss-ions	Trauma	GI	Respir-atory	Neuro-logy	Infect-ions	Cardio-logy	Other
July 2013	14	3	9	0	0	0	0	2
August 2013	14	2	9	0	1	2	0	0
September 2013	19	5	4	NR	3	0	NR	7
Total	**75**	**10**	**17**	**0**	**4**	**2**	**0**	**9**

The active record was reviewed for 10 individuals who most recently had gone to the ER and returned. The following summarizes the results of this review:

- Information was submitted indicating that the ER was notified prior to the arrival of the individual with appropriate medical background information provided for six of 10 (60%) records.
- Prior to the transfer to the ER, from the documentation, a PCP was onsite for two of these transfers. In two of two (100%) records, the PCP had written an IPN that included the date and time.
- For one of two PCP transfer IPNs (50%), vital signs were recorded.
- For two of two (100%) PCP transfer IPNs, reason for the transfer was documented.
- In two of two (100%) PCP transfer IPNs, the SOAP format was utilized.
- There were two other transfers to the ER during normal business hours. In these two cases, there was no evidence the PCP was on site.
- A copy of the ER report was available in 10 of 10 (100%).
- Of the 10 ER visits, diagnostic categories included: Trauma (five), Gastroenterology (four), and Genitourinary (GU) system (one).
- When the individual returned to the Facility after evaluation at the ER, seven of the 10 (70%) active records had a PCP IPN.
- Seven of seven (100%) post-ER visit PCP IPNs included date and time.
- Seven of seven (100%) post-ER visit PCP IPNs included recording of vital signs, or documenting attempts at vital sign measurement.

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- Seven of seven (100%) post-ER visit PCP IPNs utilized a SOAP format.
- A summary of ER information and findings were included in seven of seven (100%) PCP IPNs.
- For 10 of 10, treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER.

Data was available that tracked hospital admission. Data was provided for July 1, 2013 to September 30, 2013:

Month	Admiss-ions	Respira-tory	Neuro-logy	GU	GI	Infect-ions	Other
July 2013	6	0	0	2	3	0	1
August 2013	7	3	1	0	2	1	0
September 2013	8	0	1	0	7	0	0
Total	**21**	**3**	**2**	**2**	**12**	**1**	**1**

Additionally, nine active records were reviewed for those individuals admitted to the hospital. There were 10 hospitalizations for these nine individuals. The following provides the results of this review:

- All individuals returned to the Facility.
- Ten of 10 (100%) hospitalizations had PCP IPNs post-hospitalization.
- Of the 10 post-hospital PCP IPNs submitted, one was a report review following discussion with the hospitalist and the individual was not seen at the time of the IPN, and vital signs were therefore not indicated. For the nine remaining hospitalizations, nine of nine (100%) included vital signs or recorded attempts at vital signs.
- Ten of 10 (100%) post-hospital PCP IPNs included date and time.
- Ten of 10 (100%) post-hospital PCP IPNs had an adequate summary of hospital events and findings.
- Ten of 10 (100%) post-hospital PCP IPNs used the SOAP format.
- Ten of 10 (100%) active records of the hospitalized individuals included a copy of the hospital admission history and physical.
- Nine of 10 (90%) active records included a copy of the hospital discharge summary.
- One of the 10 included Hospital Liaison Nurse notes for the individual during the hospitalization. For two others, a Hospital Liaison Nurse report would not be indicated, because the individual was admitted on a Friday and released by Monday. For five others, there were no Hospital Liaison notes for any day of the

#	Provision	Assessment of Status	Compliance
		hospitalization. For two others, not all days of hospitalization during the week had a report. Compliance was one of eight (13%) ▪ For six of the 10 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: Gastrointestinal (eight), Pulmonary (one), and Neurological (one). LBSSLC did not have an infirmary. Therefore, no findings related to an Infirmary are made. *Pneumonia* The Facility provided the incidence of pneumonia per month. It was reported that the Avatar database was not available/accessible at the time the information was submitted. The following information was submitted separate from the Avatar database. Two documents agreed with the number of pneumonias per month. These were entitled "Individuals' Names, dates of diagnosis, specific diagnoses for past year for individuals who have been newly diagnosed with pneumonia," and an untitled document with the descriptor "the Avatar System has been down and therefore this pneumonia report is being provided." The date of onset of the pneumonia per month was as follows:	

Month	Number of pneumonia cases	Number of aspiration pneumonias	Number of bacterial pneumonias/health care acquired
April 2013	2	0	2
May 2013	7	4	3
June 2013	2	0	2
July 2013	0	0	0
August 2013	4	1	3*
September 2013	0	0	0
October 2013	3	1	2
Total	**18**		

*One may have had a component of aspiration pneumonia acquired through ventilator support.

The Facility recognized prior discrepancies in reporting the numbers and types of pneumonia. On 12/12/2013, a meeting was held to address the difference in data between the Avatar system and the Medical Department database. Information obtained at the morning provider meeting was to be utilized by both Medical and Nursing Departments. It was anticipated that this would resolve the discrepancies in

#	Provision	Assessment of Status	Compliance
		information. From a separate document entitled: "Absolute # of new cases (prior year, by month) for the following: pneumonia" the information agreed with the chart discussed above of pneumonias per month. From a separate document entitled: "For those with diagnosis of pneumonia in last six months (5/1/13-11/14/13) and taking food liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study," information was provided for 18 pneumonias. These occurred in 16 individuals. Twelve of the individuals had orders for Nothing by Mouth (NPO) and tube feeding. Three individuals had a textured diet. One had thickened liquids. One individual was deceased and the route of nutrition prior to death was not reported. To determine the completeness of evaluations for dysphagia and GERD in individuals with a history of respiratory distress necessitating ER referral and potential hospitalization, the Facility submitted data for the 12 most recent occurrences of respiratory distress for individuals sent to the hospital. The Facility provided supporting evidence for any dysphagia and/or GERD evaluations completed on these 12 individuals. For an evaluation of dysphagia, 11 of 12 had an MBSS in the past, seven had a Gastrostomy tube (G-tube) placement, and four had a Jejunostomy feeding tube (J-tube). One took food by mouth. The PNMT followed six of 12. For an evaluation of GERD, 10 had evidence of evaluation by esophagogastroduodenoscopy (EGD). For one individual, this would not have been applicable due to prior surgery and unique anatomy. Four of 12 had an Upper Gastrointestinal (UGI) series. Seven had a gastric emptying study completed (seven of 11 applicable). Four had J-tube placements. One of 12 had a prior Nissen fundoplication. From the information provided, there did not appear to be others with fundoplication. Zero of 12 indicated completion of esophageal pH monitoring. Of the 12, one had a pulmonary consult and five had gastroenterology consultation. The evaluation and treatment of dysphagia appeared appropriate. The evaluation of GERD appeared to focus on EGD evaluation for signs of reflux, as well determining presence of Barrett's esophagus or monitoring of Barrett's esophagus. Four of 11 did have information concerning gastric emptying studies. There was no information concerning tests for pH monitoring for those that may intermittently have had reflux, but no findings on EGD. The numbers of consultants were limited, and the completeness of the data was not determined, although supporting evidence of listed procedures was thorough. It is recommended that this clinical area be reviewed. It appeared that there was	

#	Provision	Assessment of Status	Compliance
		considerable variability in evaluation, types of consultants utilized, and medical/surgical options. It is recommended that for those with intermittent sudden respiratory distress, aggressive evaluations be completed to rule out intermittent reflux, which could contribute to aspiration of stomach contents. *Sepsis/bacteremia* Five individuals were diagnosed with sepsis/bacteremia for seven occurrences in the time period from May 1, 2013 through October 31, 2013. The following table provides the breakdown per month:	

Month	Number of Sepsis/ Bacteremia Cases	Month	Number of Sepsis/ Bacteremia Cases
May 2013	2	August 2013	1
June 2013	1	September 2013	1
July 2013	1	October 2013	1
Total	**7**		

Trauma
During the time period from 5/1/13 through 10/30/13, there were eight incidences of fractures. There were two incidences in which more than one fracture occurred. The fracture site included the following: upper extremity (four), lower extremity (two), ribs (one), and facial bones (one).

During the time period from May 1, 2013 through November 12, 2013, there were 27 ER visits or hospital admissions for injuries. Twenty-two individuals had 27 injuries. The following table provides the breakdown per month:

Month	Number of ER Visits/ Hospitalizations Due to Injuries	Month	Number of ER Visits/ Hospitalizations Due to Injuries
May 2013	4	September 2013	8
June 2013	1	October 2013	5
July 2013	3	To November 12, 2013	3
August 2013	3		

Chronic Conditions and Specific Diagnostic Categories
At-Risk Individuals
The integrated process for addressing individuals' at-risk issues reflected progress with some teams and less progress with others:

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		▪ For Individual #43, there were two hospitalizations and one ER visit from May 2013 through August 2013. There were significant changes in health status recorded (i.e., dehydration, placement of a PEG tube, and a gastrointestinal bleed). The record reflected several IDT meetings, with ISPA documentation in timely response to a series of changes in health status. On 5/14/13, the individual returned from the ER with a diagnosis of bronchitis causing hypoxia. An ISPA, dated 5/16/13, provided documentation of the discussion and decisions. The Disability Rights of Texas Representative attended, with focus on ensuring there were program opportunities away from the individual's residence. The Representative suggested that allergies were a potential contribution to the hypoxia, but the PCP was present and explained the need to avoid allergy treatment, given the history of chronic lung disease. A 7/16/13 ISPA reviewed an IDT discussion regarding the lack of participation in off-home programs, as well as the observation that going outside exacerbated breathing difficulties and required frequent nebulizer treatments. At that time, the RN Case Manager and PCP correlated the potential of aspiration contributing to the reactive airway disease, and the individual was scheduled for a Modified Barium Swallow Study (MBSS). On 7/24/13, the MBSS was completed, and it was recommended the individual have an order for nothing by mouth (NPO). The PCP then arranged a visit the next day with the gastrointestinal (GI) specialist. A Percutaneous Endoscopic Gastrostomy (PEG) was placed, and the individual was discharged on 7/29/13. An ISPA, dated 7/30/13, recorded the need for 24-hour nursing care, and oxygen administration, with increased treatment required by the new PEG tube. At that time, the individual became part of the PNMT caseload. Treatment for Methicillin-resistant Staphylococcus aureus (MRSA) was ongoing. A subsequent hospitalization included unstable vital signs, a GI bleed of undetermined etiology, and cellulitis at the feeding tube site. Returning on 9/3/13, an ISPA of 9/4/13 outlined seven preventive steps that were to be implemented. A follow-up ISPA, dated 11/14/13, included discussions and recommendations for tube feeding rates and positioning of pillows in his bed to both improve comfort and reduce potential harm as the individual had the ability to self-position. It was not identified if any of the post-hospital ISPAs had been accepted initially or revised prior to acceptance by the provider morning meeting. However, it appeared the team was diligent in reviewing several areas of health and safety. It is important to note that the persistence of reactive airway disease did not end with the assumption it was due to an environmental issue or was part of ongoing asthma or emphysema, but the nurse and PCP began to look at a list of potential causes. As dysphagia is a common disorder in this population, it was considered important to evaluate. This led to tube placement, followed by a decision of the team to move the individual to a different home where there was more intensive nurse monitoring. The	

#	Provision	Assessment of Status	Compliance
		individual was re-hospitalized within three weeks, and this was followed by the team identifying several concerns and steps to be taken as outlined in the ISPA. This was an example of integrated clinical care, which was provided in a timely manner. ▪ In contrast, Individual #283 had an Active Problem List, which included seizure disorder, recurrent aspiration pneumonia, dysphagia, PEG-tube placement in 2008, and gastroesophageal disease (GERD). The individual was hospitalized from 8/14/13 to 8/16/2013 for a fever. The individual subsequently developed diarrhea and was found to be C difficile positive. The ISPA, dated 8/19/13, reviewed the history and findings, but did not review any preventive steps, such as the reason for C difficile. There was also mention of opacities in the chest x-ray, but there was no further discussion. An ISPA, dated 9/19/13, documented a meeting between the PNMT and IDT in preparation for the individual's move back to the home from Quail. There was to be increased training of reflux precautions and monitoring of head of bed elevation. A follow-up ISPA, dated 10/7/13, did not provide any additional preventive steps. The individual was hospitalized from 10/8/13 to 10/11/13, and returned the same day to the hospital for readmission from 10/11/13 to 10/29/13. Originally hospitalized for pneumonia, continued hypoxia resulted in bronchoscopy being completed with multiple mucous plugs found causing atelectasis. Additional preventive steps were providing breathing treatments and increased pulse oximetry readings for one week. There was no discussion concerning preventive steps, such as whether hydration was a concern and whether urine output was to be tracked; whether respiratory therapy was consulted to provide an opinion and other pulmonary toilet options, such as chest percussion or other procedures to decrease atelectasis and mucous plugging; a follow-up pulmonary consult with a discussion of options (the individual did not have a pulmonary diagnosis listed on the Active Problem List other than a history of recurrent aspiration pneumonia); and/or the role, if applicable, for mucolytics (i.e., potential preventive steps so mucous plugging would not cause hypoxia and hospitalization again). There was no discussion of any other contributing illness that could be treated to maximize health, such as GERD (which was listed on the Active Problem List). If there were potential contributing comorbid conditions, the record did not reflect that these potential diagnoses were evaluated and treated or ruled out as not being present. The individual had a history of GERD, but there was no discussion of whether the head of bed elevation was being followed, or monitored to ensure compliance with orders, whether suction tooth brushing was done correctly (and any increased, ongoing monitoring to ensure staff were doing this appropriately). There were no action steps to determine	

#	Provision	Assessment of Status	Compliance
		whether there were any contributing environment concerns such as allergens from housekeeping cleaning agents, etc. For this individual, there appeared to be many unknowns that needed evaluation. *GERD* As part of the review of eight records, GERD was reviewed. Of the eight, four were diagnosed with GERD. Not each case would have had the listed test or procedure, but the following illustrates the spectrum of evaluation and treatment at the Facility. In part, evaluation and treatment would clinically depend on presence or frequency of signs and symptoms or illness that might be caused in part or entirely by GERD. Those with symptoms and signs controlled by medication would need fewer tests/procedures than those having additional morbidity caused from GERD. ▪ Two of four, reported completion of an EGD or UGI series. ▪ Of these four, zero had a fundoplication. ▪ Of these four, three had a feeding tube. ▪ Of these four, four had appropriate medication prescribed. ▪ Of these four, zero had a tracheostomy. ▪ Of these four, two had periodic procedures and tests for monitoring potential worsening of GERD. Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in two of four reviews. From the submitted information, it could not be determined if the clinical guidelines were followed for the remaining two of four, because further clinical information would be needed beyond the scope of the review. One additional individual of the eight reviewed did not have a diagnosis of GERD, yet had a completed Quality Indicator review for GERD. It is recommended that the Medical Department determine the criteria for the diagnosis of GERD in each individual, and to confirm/determine whether other individuals had GERD that were not included in the database for this diagnosis. *Tracheostomies* Four individuals currently had tracheostomies. *Newly diagnosed chronic conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. No individuals were newly diagnosed with diabetes mellitus type II. No individuals were newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year. *Pica* An updated and complete list of pica or ingestion of inedible objects was submitted for the time period of May 2013 through November 2013. This included nine events	

#	Provision	Assessment of Status	Compliance
		involving nine individuals. One pica incident required an immediate ER visit or hospitalization.	

Month	Number of Pica Events	ER visit	Hospitalization	Procedure/ Surgery
May 2013	2	0	0	0
June 2013	0	0	0	0
July 2013	3	0	0	0
August 2013	1	0	0	0
September 2013	1	0	0	0
October 2013	0	0	0	0
November 2013	2	1	0	0
Total	**9**	**1**	**0**	**0**

One individual required an ER visit, and one individual was hospitalized twice for gastrointestinal concerns. The information was not clear whether pica precipitated the hospitalizations. Additionally the date of incident was recorded as the "last incident" recorded for that individual, and did not reflect prior pica events during this time period. A separate document was requested that listed the individuals with pica behavior and the number of such pica events from 12/1/12 through 11/30/13. This listed 19 individuals with a pica history, of which 12 had a pica event during this period of time. The number of pica events during this time period ranged from one to 19 per individual.

Chronic constipation
Seventy-eight individuals had a diagnosis of constipation or received treatment for constipation at least weekly. A document entitled "Absolute # of new cases (prior year, by month) for the following: bowel obstructions" listed the number of bowel obstructions per month:

Month	Number of Bowel Obstructions	Month	Number of Bowel Obstructions
May 2013	1	August 2013	0
June 2013	1	September 2013	2
July 2013	1	October 2013	1
Total	**6**		

From a separate document entitled "Individuals' names, dates of diagnosis, specific diagnoses for past year of individuals who have been newly diagnosed with bowel obstruction," there was agreement of the information above except for the month of September 2013. The following data per month is derived from this additional resource:

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Month	Number of Bowel Obstructions	Month	Number of Bowel Obstructions
May 2013	1	August 2013	0
June 2013	1	September 2013	3
July 2013	1	October 2013	1
Total	**7**		

Enteral feeding tubes
The Facility submitted information that five 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 these enteral tubes (i.e., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for three of five individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. For two individuals the orders were confusing and needed further clarification. For one individual, the instructions under notes indicated, in one sentence: "All medications crushed given by g tube…" and in another statement: "all medications and feeding administered via j tube." This needed further clarification, because the individual had received a quinolone and sucralfate in the past six months. The individual might have had two tubes in place, or had changed from a G-tube to J-tube, but the directions remained confusing. For another individual, the directive was "all medication crushed given by J tube" and included a tricyclic anti-depressant. One individual was prescribed Sucralfate, but had this appropriately administered through a G-tube.

Skin Integrity
On 9/12/13, a Skin Integrity Committee met to discuss one decubitus, which was followed as of July 2013. This was a hospital-acquired ulcer, and had not resolved, but a pressure ulcer-healing graph indicated improvement. The individual subsequently expired from an unrelated chronic condition. The following chart indicates there were other decubiti, but based on submitted documentation, no other meetings of the Skin Integrity Committee were held to review these other pressure ulcers.

A document entitled "Absolute # of new cases (prior year, by month) for the following: decubitus ulcers" provided the number of new cases of decubiti per month at LBSSLC:

Month	Number of decubiti	Month	Number or decubiti
May 2013	0	August 2013	1
June 2013	0	September 2013	2

#	Provision	Assessment of Status	Compliance

July 2013	2	October 2013	4
Total	**9**		

It was noted that two of the nine originated in the hospital.

Seizure management

The Facility submitted information concerning antiepileptic medication usage.

- As of October 30, 2013, 86 individuals were prescribed antiepileptic medication. Of these, 37 percent were prescribed one antiepileptic medication, 30 percent were prescribed two antiepileptic medications, 20 percent were prescribed three antiepileptic medications, nine percent were prescribed four antiepileptic medications, and five percent were prescribed five antiepileptic medications. No individual was prescribed six antiepileptic medications.
- Additionally, 29 individuals with a diagnosis of seizures were on no antiepileptic medications.

As of 12/13/13, 29 individuals were considered to have an intractable seizure disorder. Six of these 29 had a VNS implant. There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS.

In the prior six months, eight individuals were sent to the ER for an uncontrolled/ prolonged/new onset seizure. One individual was sent to the ER four times (i.e., 5/8/13, 5/15/13, 9/13/13, and 9/24/13). One individual was sent to the ER three times (i.e., 8/22/13, 9/18/13, and 9/22/13).

Three individuals were diagnosed with status epilepticus. One individual had seizures categorized as status epilepticus twice in the prior six months.

A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 37 of 86 (43%) individuals with seizures were prescribed Dilantin, four of 86 (5%) were prescribed Primidone, nine of 86 (10%) were prescribed Phenobarbital, and zero percent was prescribed Felbamate.

Additionally, seven individuals had a vagus nerve stimulator (VNS) implant. Two of these seven were not utilizing the VNS.

The Facility submitted neurology consultation notes documenting seizure management for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records:

- Five of the five (100%) individuals had been seen more than once over the past

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		year. ▪ For two of the five (40%) individuals, the notes indicated a description of the seizures. ▪ For five of the five (100%) individuals, the notes documented frequency of seizures. ▪ For five of the five (100%) individuals, the notes included a review of current medications. One of five included dosage. ▪ For two of the five individuals, notes included recent blood levels of antiepileptic medications. ▪ For five of the five (100%) individuals, notes included recommendations. ▪ For three of the five (60%) individuals, reference was made to the presence or not of side effects. ▪ For two of the five (40%) individuals, reference was made to wellness or adequate/good control of seizures. ▪ It was noted that there was interdisciplinary attendance and discussion with an IDT member, as well as the Pharmacist, Psychiatrist, PCP, and other support staff. The clinic was efficient, and each department had additional information pertaining to the individuals if needed by the neurologist. The description of content refers to the actual neurology note as a stand-alone document in reviewing seizure management. This review should be considered in context of the dynamics of the inter-disciplinary approach at the neurology clinic. <u>Do Not Resuscitate Orders</u> A total of nine individuals at the Facility had DNR orders in place. The dates of the initiation of the DNRs were submitted. DNR orders were initiated for zero individuals in 2013, for one individual in 2012, for one individual in 2011, for zero individuals in 2010, for three individuals in 2009, and for four individuals in years prior to 2009. For nine of nine (100%), adequate clinical justification was provided for the DNR. Clinical justification included the following: three individuals had dementia, three had compromised respiratory function, two had end stage renal disease, and one had cancer. In the prior six months, the Facility Ethics Committee met on 8/14/13 to discuss specific individuals to review DNR status. Minutes of the Facility Ethics Committee included the following components: ▪ The meeting minutes documented date and time. ▪ The meeting minutes included the name of the individual for discussion of DNR. ▪ The meeting minutes listed names of attendees. ▪ The meeting minutes included a signature sheet. ▪ The meeting minutes included a synopsis of the proceedings and critical review of information.	

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		▪ The meeting minutes included a summary of critical discussion with family/guardian. ▪ The meeting minutes included discussion by the PCP. ▪ The meeting minutes included a recap with recommended action steps outlined. ▪ The meeting minutes included a copy of DNR documentation consistent with the decision of the ethics committee. An additional Ethics Committee meeting was called on 12/6/13 to change an individual from full code to Resuscitative Status Two. This was documented in an ISPA format. An earlier 11/13/13 ISPA reviewed the medical condition and family agreement with the decision. The contents of the ISPA were as follows: ▪ Documented the date of the meeting and the time. ▪ Documented the list of attendees on the signature sheet. ▪ Provided a synopsis of the proceedings and critical review of information. ▪ Included a summary of critical discussion with the family/guardian. ▪ Included the discussion by the Medical Director ▪ Included a recap with recommended action steps outlined. ▪ Included a copy of DNR documentation consistent with the decision of the ethics committee. It is recommended that the Facility create one format to be used for the Ethics Committee minutes. Both appeared comprehensive, but standardization of the documentation should be considered. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Non-Facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review (Round Eight). The following represents a synopsis of the information: ▪ For the one external peer review dated 8/1/13 to 8/2/13, although the document indicated: "an asterisk '*' indicates an essential element," none of the 46 clinical indicators for the Medical Provider Quality Assurance Audit and none of the Medical Management Audit clinical probes (i.e., four clinical indicators for UTI, five clinical indicators for constipation, and six clinical indictors for seizures) were marked with an asterisk. The Facility did not provide a breakdown of PCP compliance in essential and non-essential areas. Based on submitted information, the Monitoring Team member could not calculate percentage compliance per PCP in essential and non-essential areas. ▪ The external audit review process information did indicate the number of	Noncompliance

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		records chosen for review (i.e., 13 records using the general medical review audit and nine records using the medical management audits). ▪ The external audit review process information did indicate how the sample was obtained. ▪ There were 46 clinical indicators listed on the "Medical Provider Quality Assurance Audit." Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: (2) Is there evidence that the Active Problem List was updated with each problem? (4) Is the Annual Physical Exam complete, including past medical history, family history and a plan of care? (9) Has the Measles/Mumps/Rubella immunization been given? (19) Have the appropriate preventive screenings for colonoscopies been provided? (25) Have the appropriate preventive screenings for vision been provided? (30) Do the Medication Orders for Acute Conditions include indication and duration for all the medications prescribed? (33) Are responses to significant lab values documented in the integrated progress note by the provider? (42) Did the provider indicate resolution and closure of acute problems in the integrated progress notes? (45) Are medical and/or surgical consultation recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? (It was noted there were two records with audit findings of deficiencies, but review by the Medical Department indicated it had been misfiled in another individual's medical record.) ▪ From the external Medical Provider Quality Assurance Audit, there were 16 corrective action plans generated. ▪ An external Medical Management Audit for Round Eight was also completed on 8/1/13 to 8/2/2013. The three areas of clinical focus were: Urinary tract infection, seizures, and constipation. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: UTI (1) Is Urinary Tract Infection listed on the Active Problem List? (2) Did the provider prescribe the appropriate interventions and/or treatments? (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? ▪ There were no areas needing improvement based on the results of the medical management audit for seizures and constipation. All PCPs scored 100 percent on these two clinical areas. ▪ From the external medical management audit for Round Eight, there were three corrective action plans generated. These were all for the clinical focus on urinary tract infections. ▪ There was one external reviewer. This one reviewer provided the Facility with a	

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		summary of the review at the exit. This was reflected in a document entitled "Medical Provider Non-Facility Review," dated 8/2/13. This was a one-page document, but it appeared there might have been one or more additional pages, which were not copied, as it ended abruptly, and did not list the staff member who conducted the review. ▪ From the "Medical Provider Non-Facility Review" of 8/2/13, areas needing improvement were listed/identified as: o Developing a standardized approach to attempt to obtain family history. o This was the only area needing improvement in the submitted document. However, this statement appeared at the bottom of the page, and there was no additional page, suggesting the submission was incomplete and there may have been additional areas needing improvement. ▪ From the "Medical Provider Non-Facility Review" of 8/2/13. Areas considered strengths were listed/identified as: o Quarterly Drug Regimen Reviews were reviewed and signed in a timely manner. o Quarterly Medical Reviews were up-to-date. They had a very focused format and provided important information. o Annual Physical Examinations were up-to-date and informative. o Ninety-day medication orders included dosage, frequency, route, duration, and diagnosis for all the medications. o Preventive Care Flow Sheets were completed and signed. o Consultation referrals were signed, dated, and clearly indicated whether the PCP agreed or disagreed with the consultant's recommendations. o Medication orders were completed, including the diagnosis and the duration of therapy. ▪ Compliance rates for the external Medical Provider Quality Assurance Audit were calculated for each PCP. Scores ranged from 95 percent to 99 percent. For each record, there were a potential of 46 clinical indicators, but not all clinical indicators were applicable to each record. From 22 to 34 clinical indicators were applicable to the medical record during the audit. ▪ Compliance rates for the external QA Medical Management Audit were calculated for each PCP. Scores were categorized by clinical focus. For the urinary tract infection audit, compliance ranged from 50 to 100 percent. For the seizure audit, and constipation audit, compliance was 100 percent for all PCPs. ▪ There was no QA review of audit results to determine the most common areas of noncompliance that might need additional focus. However, areas of concern were reviewed. At the Medical Department meeting of 8/8/13, results of the external medical peer review QA audit were reviewed. In response to one of the noncompliant areas, a "Family medical history form" was reviewed and	

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		approved for use. It was to be sent to the responsible representative for completing known information concerning family history of medical diagnoses. As this would be sent through the QIDPs, an interdepartmental meeting was to be held to discuss implementation and processing of this form. As an example of the QI process, this had a positive impact. The form was subsequently implemented. Reportedly, as of 12/18/13, 95 of 203 (47%) individuals had the form returned from the responsible parties. In addition, one area from the external Medical Provider Quality Assurance Audit was identified and addressed during a medical staff in-service 8/22/13 (Clinical indicator #30). ▪ The above external audit review process for Round Eight reviewed 22 of 202 records, which was 11 percent of the records at the Facility. If this were consistently done every six months, this would meet the goal of 20 percent compliance annually. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The QA nurse/QA Department compiled compliance data with corrective action plans distributed to the Medical Department. ▪ The QA Department tracked corrective action plan resolution every 90 days or sooner until resolution. The QA Department submitted a document entitled "Action Plans and QA Follow-up," which tracked each corrective action plan (both the external and internal corrective action plans for the August 2013 audits were listed in the same tracking document). ▪ During this 90-day time period, the QA Department determined that four of four (100%) providers corrected all deficiencies. Fourteen deficiencies were tracked and 14 (100%) were corrected from the Medical Provider Quality Assurance Audit. There were two additional deficiencies determined through this audit that were clerical/administrative concerns not related to the PCPs, and they were not tracked in this process. ▪ During this 90-day time period, the QA Department determined that three of three (100%) corrective action plans for the external Medical Management Audit had been completed. ▪ The Medical Department staff meeting minutes documented a discussion of the results of the external peer review findings needing further in-service training. On 8/22/13, four of four PCPs attended this meeting. It included a review of four clinical indicators identified as needing improvement (i.e., one from the external peer review audit and three from the internal peer review audit.). ▪ The Medical Department staff meeting minutes documented additional information and guidance for improvement/implementation/documentation to reduce deficiencies for four of four identified clinical indicators needing improvement.	

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		The Facility has implemented an external medical peer review process that demonstrated a review of 20 percent of medical records annually. In addition, the Facility had a QA system that monitored for timely correction of action plans, and in-service training for areas needing improvement. However, there was a need for State Office to create and conduct further medical management audits, because the six currently being utilized were the only medical management audits for the external review process. <u>Mortality Reviews</u> According to a submitted document, dated 11/15/13, the Facility had no outstanding clinical mortality reviews for deaths. Clinical and administrative death reviews were submitted for the time period of August through October 2013. There were seven deaths during that time: ▪ The average age was 54 (varied from 29 to 83). ▪ Five died under the age of 65, and two died at age 65 or greater. ▪ Of the deaths, two were females, and five were males. ▪ The causes of death were: breast cancer (one), sepsis (four), pneumonia (two), restrictive airway disease (one), failure to thrive (one), and subdural hematoma (one). Some had more than one diagnosis listed. ▪ An autopsy was performed in one of the seven. ▪ DNR status was ordered while residing at LBSSLC for four of the seven, and ordered for three while in the hospital. One had DNR in both settings. One was a full code in both settings. ▪ DNR status was in place prior to the final acute illness for six of seven individuals. ▪ Three died in a hospital setting. ▪ Four died at the Facility. ▪ Four had multiple or prolonged hospitalizations within six months prior to death. ▪ Three had been hospitalized within four months of death. ▪ Five had feeding tubes in place. ▪ Four were enrolled in hospice. ▪ Two were considered ambulatory (i.e., either independently or with assistance). Since the Monitoring Team's last visit, seven clinical death review investigations and seven 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. ▪ Of these seven death reviews, seven administrative death reviews had follow-up recommendations.	

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		▪ Administrative death reviews included from five to 10 recommendations per review, for a total of 56 recommendations. Several recommendations were similar at each of the mortality reviews. ▪ Systemic issues related to potential improvements in medical care were zero of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were 45 of the 56 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 represented one of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in pharmacy services were zero of the 56 recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were zero of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies were zero of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in residential care were eight of the 56 recommendations. ▪ Systemic issues related to potential improvements in meaningful day activities (i.e., work, leisure programs, etc.) were zero of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to medical records represented one of the 56 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in other departments (i.e., maintenance, housekeeping, furlough, etc.) represented one of the 56 recommendations from the administrative death reviews. ▪ The Facility submitted follow-up documentation for 52 of 56 (93%) recommendations. Fifty-one of 52 required training. One recommendation did not. Of the 52 that required training, a copy of the content was submitted for 52 (100%). The name of the instructor was submitted for 22 of 52. A copy of the attendance-training roster was submitted for 26 of 52. It was noted that the four recommendations, which had no evidence of closure involved three individuals. This demonstrated a system was in place to track closure of recommendations from the death review process. The quality of the documentation of training would benefit from improvement (i.e., name of instructor and title, and ensuring training rosters were available as evidence of training). However, in general, the Facility was addressing recommendations resulting from the mortality reviews, and had a system in place to track them through to conclusion. In summary, the LBSSLC mortality review system was producing reviews that included	

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		valuable recommendations, and the Facility had a system to implement and track the recommendations to conclusion. The non-facility physician reviews were occurring, and on an annual basis, they included a sample of 20% of the individuals served. The Facility had a system to track the action plans that resulted from these reviews through to completion. In addition, the Facility was reviewing the deficiencies to identify need for more systemic action and/or training. Some changes had occurred as a result of the findings. The remaining concern was the fact that these reviews included limited topics, and did not comprehensively assess the quality of medical care at the Facility. In order for substantial compliance to be achieved, further expansion of the scope of the reviews is needed.	
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 the August 5 through 8, 2013 internal medical peer review was provided. The audit questions were identical to those used in the external medical peer review audit (for the Medical Provider Quality Assurance Audit as well as the Medical Management Audit reviewing the same three clinical areas (i.e., UTIs, seizures, and constipation). The medical records the external peer review auditor reviewed were the same medical records reviewed during the internal medical peer review audit. A document entitled: "Internal Medical Provider Review" dated 8/8/13 summarized the process and findings of this internal review. Four of four PCPs participated in conducting the review and the Medical Director provided the summary. Compliance for PCPs in essential areas and non-essential areas could not be determined, because this information was not available for Round Eight. This document provided the summary findings/analysis of the internal review for August 2013. ▪ According to the Facility's review, areas that were identified as strengths included the following: o Active Problem Lists were signed and dated; o Annual summaries contained appropriate information; o Documentation was provided for Allergies and Tobacco use; o Immunizations and preventive care was good; and o Documentation was appropriate for ancillary testing, consultations, and QDDR reviews. ▪ The internal review noted the following areas which remained a challenge: o Updating the Active Problem List was lacking in two of 13 records; o Documenting the MMR vaccination was lacking in three of 13 records; o Colonoscopy screening needed to be performed in two of 13 records/patients; and o Follow-up on the effectiveness of constipation medication needed improvement. The results of the internal peer review for the Medical Provider Quality Assurance Audit	Noncompliance

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		indicated the following: ▪ There were 17 concerns leading to the creation of 17 corrective action plans. Areas initially identified as needing improvement included answers to the following audit probe questions: o (2) Is there evidence that the Active Problem List was updated with each new problem? (3) Is there evidence that the Active Problem list was updated as problems were resolved? (9) Has the MMR immunization been given? (13) Has the PPD been given? (16) Has the Hepatitis B vaccine been given? (17) Have the appropriate preventive screenings for mammograms been provided? (19) Have the appropriate preventive screenings for colonoscopies been provided? (26) Was the preventative care flow sheet updated at the time of the last annual assessment? (33) Are responses to significant lab values documented in the integrated progress note by the provider? (37) Is the provider's documentation legible? ▪ Compliance per physician ranged from 95 percent to 98 percent. Of the 46 potential clinical indicators for each medical record, the applicable number of questions per chart ranged from 26 to 42. For the internal medical management audit, a total of four concerns were noted that generated corrective action plans. There was one corrective action plan for the Urinary Tract Infection audit, none for the seizure audit, and three for the constipation audit. Areas needing improvement including the following audit questions: ▪ Urinary Tract Infection (3) Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN for that individual's response? ▪ Constipation (3) Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects? (5) Did the provider complete an assessment and provide further interventions for the individual who was identified as having no BM after medical interventions? Compliance per physician ranged from 75 to 100 percent for the Urinary Tract Infection audit, 100 percent compliance with the seizure audit, and 60 to 90 percent for the constipation audit. There was information submitted concerning tracking these corrective action plans to closure. The QA Department submitted a document entitled: "Action Plans and QA Follow-up" for corrective action plans from the internal peer review audits completed in August 2013. There were 17 corrective action plans followed from the internal Medical Provider Quality Assurance Audit. Seventeen of 17 (100%) were completed. There were an additional four corrective action plans from the internal Medical Management Audit	

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		which were tracked. Four of four (100%) were completed. Minutes were submitted for a meeting entitled: "QA Medical Audit Round 8 CAP requiring an in-service," dated 8/22/13. At this meeting, four audit questions were identified and reviewed with development of guidance/plans for improvement. One of the four was from the external peer review audit of August 2013. The other three were from the internal peer review audit of August 2013. Results of the external and internal medical peer review audits were reviewed in the document entitled: "QA/QI Quarterly Summary - September 2013 (Sections G, H, L)." Contents reviewed included the sample selection process, strengths identified on analysis of results, areas that needed improvement identified through analysis of results, and comments by the QA nurse. There were notations in this section that needed further administration review and potential implementation, if approved. However, there was no information concerning whether these comments had any closure. They were: "Consider a modification to the current formalized tracking system to ensure dictated progress notes, consults, etc., are being placed in the active record in a timely manner. Consider a formalized system to document (in the active record) the actual documents sent to consultant/referral appointments." These appeared to be Facility administrative closure concerns. The "Department and QA Meeting Notes" for Section L were submitted. This meeting was scheduled monthly. The 5/25/13 documentation indicated that the meeting was deferred, because the May 2013 internal audit was being conducted. The 6/19/13 documentation indicated the meeting was deferred, because "round 7 internal from May 2013 does not yet have an action plan." The 7/18/13 meeting was deferred due to the "onsite monitor visit and no action plan for round 7 internal/external." The 8/22/13 scheduled meeting was deferred due to "all items closed out." This indicated that the August internal and external medical peer review audits had been completed within 30 days of the audit findings. An internal medical peer review audit was scheduled for completion on a quarterly basis. The Medical Department submitted a document entitled: "Internal Medical Provider Review" dated 11/18/13. This summarized the findings of the internal medical review audit of November 12 to 15, 2013. Findings indicated the following: ▪ Twelve records were reviewed using the Medical Provider Quality Assurance Audit. Nine records were reviewed using the Medical Management Audit for monitoring the clinical guidelines for osteoporosis, aspiration pneumonia, and diabetes mellitus. ▪ Areas needing improvement were listed as: o MMR immunizations needed to be updated for multiple individuals.	

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		o Legibility issues continue as a problem, but the use of dictation had improved this problem. o One individual was in need of a consultation referral. o One record did not have updated 90-day orders present. ▪ Areas indicating strengths included the following: o Improvement updating the Active Problem List was noted. o Essential elements were found in all Annual Physicals. o Preventive care was up-to-date, the exception being the MMR vaccinations. o Acute and emergency care was appropriate along with utilization of ancillary services and consultations. o The Medical Management areas did not require any corrective actions. On 11/10/13, a Medical Department meeting was held at which the findings of this internal audit were reviewed. Specific plans were documented and served as the corrective action plans. A review of the audits indicated the following audit questions needed improvement. Four areas had multiple repeat noncompliance concerns. These were identified by the Medical Director and discussed in the medical staff meeting of 11/19/13: (2) Is there evidence that the Active Problem List was updated with each new problem? (3) Is there evidence that the Active Problem List was updated as problems were resolved? (9) Has the MMR immunization been given? (37) Is the provider's documentation legible? Additional audit questions needing improvement included the following, but it was not clear when or how they were addressed: (6) Are drug and/or food allergies, intolerances or reactions appropriately documented? (8) If the individual uses tobacco products, was there documentation for recommendations for cessation of tobacco use? (27) Is the current 180-day physician order present in the record, and does it document the indication for each medication/order for medication to be discontinued? (42) Did the provider indicate resolution and closure of acute problems in the integrated progress note? (45) Are medical and/or surgical consultation recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? (46) If consultation recommendations are not implemented, is there a clear rationale from the provider in the integrated progress note as to why they have chosen not to implement the recommendations? The Facility provided information concerning the PCP compliance with essential and nonessential components of the Medical Provider Quality Assurance Audit for November 2013. For essential components, PCP compliance ranged from 83 to 100 percent. Three PCPs scored 100 percent in this area. For non-essential components, PCP compliance	

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		ranged from 93 to 100 percent. For the internal Medical Management audit, all PCPs scored 100 percent. A document submitted indicated that the QA Department had not followed up on the corrective action plans for the November 2013 internal medical peer review audit. Due to the recent timing of the review and the need for a 30-day period for the PCPs to complete the action plans, the QA nurse had not monitored progress. The Medical Department did submit documentation of corrective actions completed for several areas of noncompliance. The QA Department provided a separate copy of the medical provider review for November 2013, with the action plans that were needed. There were 20 action plans from the Medical Provider Quality Assurance Audit. Data from the May 2013 internal medical management audit was also submitted. Two clinical indicators were identified in more than record as needing improvement on the Medical Provider Quality Assurance Audit: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? and (26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant? For the Medical Provider QA Audit of May 2013, compliance among PCPs for essential elements ranged from 94 to 100 percent. Compliance among PCPs for nonessential elements ranged from 89 to 100 percent. There were nine action plans generated, QA followed these to completion. There were two action plans for the medical management audit. QA followed these to completion. It was noted that corrections for the 5/15/13 audit did not occur at the 30-day QA review (6/13/13) or at the 60-day review (7/2/13). Eleven action plans remained outstanding as of 7/2/13. A follow-up chart indicated that QA indicated closure on 8/22/13 to these 11 action plans. A delay of up to 90 days after the initial findings for closure of all action plans should be reviewed to identify potential steps for improvement. The reason for the delay was not indicated, although earlier Medical Department QA meeting notes indicated there might have been a delay in distributing the corrective action plans. <u>Inter-rater reliability</u> The QA Department provided inter-rater reliability scores for the past six months. The QA representative tracked audit scores by comparing audit scores from the external peer review results (i.e., one reviewer in August 2013), and the PCPs completing the internal peer review. Results indicated the following: ▪ Monitoring tools used were identical; ▪ The medical management diagnoses reviewed were also identical; ▪ Data was submitted that compared answers from the external to the internal reviewer to determine the need for further guidance on specific clinical	

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indicators;
▪ Inter-rater percentage agreement with the Medical Management Audits ranged from 83 to 100 percent per provider. Given the results of the two reviews as discussed above with regard to Section L.2 and this subsection, this did not appear accurate. The finding varied considerably between the external and internal reviews. If in fact, inter-rater reliability had been as high as reported, one would expect to see much less variability in the findings;
▪ Inter-rater percentage agreement with the Medical Provider Quality Assurance Audit was not submitted to allow comparison of the external reviewer results to the PCP internal peer review results. Submitted was one graph for each of the questions in the Medical Provider Quality Assurance Audit, but the results indicated 100 percent compliance for external and internal scores, indicating 100 percent agreement. This chart did not indicate if this referred to all four PCPs or one specific PCP. Additionally, the title "inter-rater compliance by question" needed to be defined for clarity. It was not clear whether the word "compliance" meant agreement between reviewers, or whether compliance indicated both the external and internal scores found the question to be over a threshold indicating Medical Department compliance with that clinical indicator.
▪ The database appeared to allow staff the ability to identify questions that were answered differently between the reviewers. However, there was no information whether the QA Department analyzed this information to prioritize areas needing review, development of guidelines or standards, and/or in-service training.
▪ There did not appear to be any actions taken to improve inter-rater reliability for areas identified with discrepancies.

<u>Medical Department Internal Reviews/ Initiatives and Improvement Projects</u>
The Medical Department had implemented the following additional processes for internal peer reviews:
▪ Quality indicators were identified for 11 clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. The number of clinical indicators per clinical area were:

<table>
<tr><th>Clinical Area</th><th>Number of Clinical Indicators</th><th>Clinical Area</th><th>Number of Clinical Indicators</th></tr>
<tr><td>Tuberous sclerosis</td><td>3</td><td>Seizures</td><td>5</td></tr>
<tr><td>Constipation</td><td>5</td><td>Metabolic syndrome</td><td>6</td></tr>
<tr><td>ER/Hospital</td><td>5</td><td>Osteoporosis</td><td>6</td></tr>
</table>
</td><td></td></tr>
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Visits			
Diabetes Mellitus	7	GERD	5
Ogilvie Syndrome	6	UTI	5
Down's Syndrome	5		

Per clinical area, the number of individuals, dates, and score range are included in the following chart:

Clinical Area	2013 Date of Audit	Number of Individuals	Score or Score Range
Tuberous sclerosis	8/16/13	1	100%
Tuberous sclerosis	9/18/13	1	100%
Seizures	8/20/13	3	100%
Seizures	9/22/13, 9/26/13	2	100%
Seizures	10/4/13	1	100%
Seizures	11/14/13	1	100%
Constipation	7/16/13	2	100%
Constipation	8/13/13, 8/14/13, 8/20/13	4	100%
Constipation	9/25/13, 9/26/13	2	100%
Constipation	10/3/13, 10/4/13, 10/9/13, 10/16/13	4	100%
Constipation	11/14/13, 11/19/13	2	100%
Metabolic Syndrome	7/16/13	1	100%
Metabolic Syndrome	10/22/13	1	100%
ER/Hospital	8/6/13, 8/12/13, 8/14/13, 8/16/13, 8/22/13, 8/25/13, 8/28/13	7	100%
ER/Hospital	9/1/13, 9/18/13, 9/26/13	3	100%
ER/Hospital	10/15/13, 10/17/13	2	100%
ER/Hospital	11/19/13	2	75-100%
Osteoporosis	8/13/13, 8/19/13, 8/20/13	4	100%
Osteoporosis	9/25/13	1	100%
Osteoporosis	10/3/13, 10/4/13, 10/9/13, 10/15/13	5	100%

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Osteoporosis	11/14/13, 11/19/13	2	100%
Diabetes Mellitus	9/22/13	1	85.71%
Diabetes Mellitus	10/9/13, 10/16/13, 10/22/13	3	66.67-100%
Diabetes Mellitus	11/13/13, 11/14/13, 11/19/13	3	100%
GERD	9/26/13	2	100%
GERD	10/7/13, 10/9/13, 10/15/13, 10/16/13	4	100%
GERD	11/14/13, 11/19/13	2	100%
Ogilvie Syndrome	10/14/13	1	100%
Ogilvie Syndrome	11/22/13	1	100%
UTI	11/12/13	1	100%
Down's Syndrome	10/18/13	1	100%

These audit tools provide a synopsis of care of these individuals at LBSSLC. From a quality improvement perspective, the large number of 100 percent scores indicates that the Medical Department needs to review areas of challenge and concentrate efforts on those areas. It is important to demonstrate the quality improvement process, but if the chosen categories or questions asked do not focus on areas of need, then areas needing improvement will not be identified. An area identified as needing improvement should have baseline data, followed by in-service education and expectations, followed by a time period to allow improvement, and then a repeat audit for results. If there is improvement in the scores, the process has matured. If the scores are unchanged, further intervention, education and monitoring is indicated until improvement occurs. As is discussed with regard to Sections L.1 and I.2, the Monitoring Team was continuing to identify issues that the Facility's internal processes were not identifying. For example, although some improvement was seen for medical evaluations and planning for individuals at-risk, a number of problems continued to be identified. It is essential that the Facility's internal medical quality assurance systems identify such issues, and develop and implement corrective actions to address them.

An example of a good quality improvement process was the review of noncompliance with one of the quality clinical indicators for diabetes mellitus. On 10/29/13, a Medical Department meeting included further review and training on this area. Additionally, at the 11/6/13 Medical Department meeting, this area was again addressed. Audit results over time will determine whether the review had a positive impact on compliance with expected clinical care in this area.

An example of a clinical area needing focus is the evaluations completed for those going

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		to the ER for acute onset of respiratory distress. Data reported with regard to Section L.2 indicated that dysphagia evaluations were complete, but that GERD evaluations varied and might have lacked important components. This is a different question than reviewing those with a diagnosis of GERD. For those with acute onset of respiratory distress, the goal is to prevent a recurrence, and the cause might be multiple or varied from individual to individual. However, acute reflux and aspiration of stomach acid might produce acute respiratory distress, and should be ruled out. If it is the causative agent, then acute respiratory distress will continue to recur until diagnosed and treated medically and/or surgically. Those with acute respiratory distress might not be part of the population audited by a GERD diagnosis if it is not known that GERD exists in that individual. This would be missed with the current audit. Other areas might include those repeated noncompliant areas of the medical provider quality assurance audits or the medical management audits. Areas identified through the clinical death reviews would also be appropriate areas of focus. From open record reviews, areas of medical care needing improvement or systems issues affecting medical care involving other departments might be identified. The Medical Department provided evidence of a developing quality improvement program. The growing number of quality indicator provided evidence of reviews of quality care, which was reassuring and necessary. The Medical Department should continue this process, with focus on areas needing improvement. Areas in which improvements continued to be needed included: ▪ As is discussed with regard to Sections L.1 and I.2, the Monitoring Team was continuing to identify issues that the Facility's internal processes were not identifying. For example, although some improvement was seen for medical evaluations and planning for individuals at-risk, a number of problems continued to be identified. It is essential that the Facility's internal medical quality assurance systems identify such issues, and develop and implement corrective actions to address them. The Facility should review the current audit tools and processes, and refine them to ensure they are sensitive enough to identify such issues. ▪ As is discussed with regard to Section H.6, the Medical Department also needed to demonstrate creation of audit tools with clinical indicators focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (e.g., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit should measure whether there was evidence that change occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, need for further consultation, or need for	

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		further lab testing, scans, etc. ▪ Reasons for delays of up to 90 days for the completion of corrective actions resulting from internal quality reviews required review, and determination of whether actions were needed to improve the timeliness of these activities. ▪ Based on the results of the internal and external reviews, it did not appear that inter-rater reliability had been established, even though the inter-rater reliability scores the Facility provided for the Medical Management Audits were high. ▪ The QA Department has shown inter–rater reliability information for the Medical Management audit, but inter-rater reliability data from the Medical Provider Quality Assurance audit was not provided. ▪ Areas in which there were differences in inter-rater reliability should be investigated to determine the reason for discrepancies in scoring, and develop guidelines and standards, and/or provide in-services or other training as needed.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the Monitoring Team's last visit, the following policies/procedures/protocols were approved and/or implemented: ▪ "LbSSLC – Health Services: Life Sustaining Treatment," dated 12/20/13 (R); ▪ "LbSSLC – Health Services: Medical Care Policy," dated 8/22/13; ▪ "LbSSLC – Health Services: Morning Provider Meeting – Integrated Clinical Services," dated 9/25/13; and ▪ "LbSSLC – Health Services: Planning End of Life Care and Death of an Individual," dated 12/20/13 (R). The policy on provider morning meetings and the policy on planning end of life care (which included the Facility collaboration with Hospice) were important additions to the policy manual and provided guidance to the Facility departments. There were no policies submitted in draft format. The Facility provided a copy of the "Medical Policy and Procedure Manual/Treatment Guidelines." The following policies were listed in this manual: ▪ "LbSSLC - Health Services: Administration of IV fluids and IV antibiotics," dated 5/23/11; ▪ "LbSSLC – Health Services: Choking," dated 1/3/11; ▪ "LbSSLC – Health Services: Coding Requirements," dated 4/18/11; ▪ "LbSSLC – Health Services: Life Sustaining Treatment," dated 12/20/13 (R); ▪ "LbSSLC – Health Services: Medical Care Policy," dated 8/22/13. The Medical Care Policy included a discussion of documentation requirements (i.e., general documentation; active problem list; documentation of acute medical problems;	Noncompliance

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		addressing chronic health problems; consultations; hospitalizations, including transfers/readmissions/discharges; annual medical assessments/annual medical summary/plans of care; and pharmacist concerns), communication by individual or representative, meeting attendance for PCPs, management of acute illness or injury, seizure management, aspiration pneumonia, management of chronic conditions, prevention, and quality of medical care; ▪ "LbSSLC – Health Services: Medical Peer Review," dated 8/29/12; ▪ "LbSSLC – Health Services: Morning Provider Meeting – Integrated Clinical Services," dated 9/25/13; ▪ "LbSSLC – Health Services: Planning End of Life Care and Death of an Individual," dated 12/20/13 (R); ▪ "LbSSLC – Health Services: Preventive Medicine," dated 3/1/12; ▪ "LbSSLC – Health Services: Process for On-Campus and Off-Campus Consultations," dated 4/1/13; ▪ "LbSSLC – Health Services: Seizure Management," dated 7/2011; ▪ "LbSSLC – Health Services: Submission of Timely Annual Physical Assessments," dated 4/18/11 ▪ "LbSSLC - Health Services: Tracking System for Health Care Professional Licensure," dated 8/29/11 (R) ▪ "LbSSLC – Health Services: Tracking System for Lab/Radiology Department," dated 8/29/11 (R); and ▪ "LbSSLC - Health Services: Transportation of LbSSLC residents in nonemergency conditions," dated 6/13/11. Protocols and Procedures included: ▪ "Needle stick/Bloodborne Pathogen Protocol." This protocol included "Protocol for blood draws in lab," dated 6/13/12, and "Recommended PEP for exposure to HBV/HCV/HIV." Clinical Guidelines included: ▪ "LbSSLC – Health Services: Clinical Guidelines – Anticoagulation Therapy," dated 4/3/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Aspiration Pneumonia," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Constipation," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Diabetes," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Down Syndrome," dated 10/25/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Enteral Feedings," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Metabolic Syndrome," dated	

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		10/25/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Osteoporosis," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Prader–Willi Syndrome," dated 10/25/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Seizures," dated 1/13/12; ▪ "LbSSLC – Health Services: Clinical Guidelines – Tuberous sclerosis," dated 10/25/12; and ▪ "LbSSLC – Health Services: Clinical Guidelines – UTI," dated 2/3/12. Quality indicators for the provision of care had been developed for: Aspiration pneumonia, constipation, diabetes, Down Syndrome, ER/hospital visits, GERD, metabolic syndrome, Ogilvie syndrome, osteoporosis, Prader-Willi, seizures, tuberous sclerosis, and UTI. It was noted that the quality indicators did not have a date of completion or implementation. In the future, revisions should be dated to ensure that the tool being utilized is the most current tool, and review of results should include reference to which revision (or original document) was utilized. As clinical indicators are added or removed, without a date of identification, the database results, which often list the clinical indicators by number, would need to list the date of revision (or date of original document) to ensure the analysis interprets the numbering of the clinical indicators correctly. Other areas that require formal policy/procedure guidance include: determination of caseloads for PCPs, CPR certification, and tracking of missed specialty appointments (both offsite and on campus, including guidance as to what is considered a missed appointment for purposes of calculations, to create a standardized system of review). The "Medical Care Policy" included a section on meeting attendance by PCPs, but did not include guidance for attending post-hospital ISPAs. In the "Morning Provider Meeting" policy, reference was made to an open record review template. A copy of the template as an addendum or appendix to the document would provide further clarity to the policy. Important data is generated from the morning provider meetings (i.e., number of concerns with closure, ISPAs reviewed and approved or not, open record reviews assigned and completed per month, etc.). An addition to the "Morning Provider Meeting" or a separate policy describing the data, analysis, and reporting of this information to the Medical Department and the QA/QI Council would formalize and memorialize a process already in place. Additionally, policies and procedures should be modified whenever changes occur, and formal review should occur at least every three years, as outlined in the Facility's policy that described policy and procedure development and approval. On a departmental level, given the changing field of medicine, it would be important to operationalize the review process to ensure that policies and procedures are updated as	

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		needed, and not only every three years.	

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 the 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 Provision Action Information; 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 #100, Individual #43, Individual #225, Individual #161, Individual #176, Individual #171, Individual #196, Individual #191, Individual #139, Individual #324, Individual #128, Individual #323, Individual #226, Individual #312, Individual #6, Individual #293, Individual #89, Individual #283, Individual #269, Individual #23, Individual #179, Individual #167, Individual #127, Individual #147, Individual #235, Individual #284, Individual #170, Individual #70, Individual #52, Individual #312, Individual #309, Individual #300, Individual #204, Individual #320, Individual #8, Individual #90, Individual #100, Individual #192, Individual #104, Individual #283, Individual #84, Individual #80, Individual #64, Individual #61, Individual #291, Individual #81, Individual #79, Individual #19, Individual #230, Individual #76, Individual #43, Individual #317, Individual #233, Individual #74, Individual #211, Individual #284, Individual #308, and Individual #168; 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 raw 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 12/23/13; o LBSSLC's list of individuals affected by outbreaks; o LBSSLC's Presentation Book regarding Outbreak information; o Quarterly Emergency Response Drill data; o Standard Precautions Monitoring Tool data; o Medication count pilot procedure: o Residential Medication Pass Observation data; o Medication Observation raw data; o Medication Variance data by month;

	○ Unexplained Returned Medication data; ○ Returned Medication data by home; ○ Medication Observation Tracking data; ○ Medication Variance data and graphs; ○ Pharmacy Spot Check Medication Accountability Audit data; ○ Raw data from the Nursing Chart Review audits; ○ Medication Variance Improvement Process; ○ Medication Refill LVN job description; ○ Environmental audits and raw data; and ○ Entrance Presentation information. ▪ **Interviews with**: ○ Brandi Villarreal, RN, BSN, Chief Nurse Executive (CNE); ○ Lilly Burton, RN, Program Compliance Nurse (PCN); ○ Jennifer Simmons, RN, BSN, Nurse Operations Officer; ○ Linda Skinner, RN, BSN, Quality Assurance Nurse; ○ Norman Elstone, RN, Quality Assurance Nurse; ○ Scott Craig, RN, BSN, Case Manager Supervisor; ○ Eric Benson, RN, Infection Control (IC) Nurse; ○ John Todd, R.Ph., Clinical Pharmacist; ○ Mary Ortiz, Competency Training Department (CTD); ○ Robin Seale, Assistant Director of Programs; ○ Ruth Clark, RN, Quality Assurance Nurse; and ○ Matt Peterson, Training Specialist I. ▪ **Observations of**: ○ Medication Administration in the Quail; ○ Use of emergency equipment at Rose and Zinnia; and ○ Medication Safety and Systems Committee meeting, on 1/9/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. 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 M, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Since the last review, turnover in staffing had resulted in some gaps in the auditing process, as well as the need to re-establish inter-rater reliability for the monitoring tools the Facility was using at the time of the review. In addition, the Facility had developed and implemented a Nursing Chart Review audit. However, the Monitoring Team's review of the tool found some 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 did not have formal processes in place to trend and analyze the data that had been generated. Although some 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 It was unclear why some of the specific data included in the Self-Assessment were presented, because it appeared the data 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, and were not consistent with the requirements of the Settlement Agreement and the indicators the Monitoring Team used. 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 essentially no inter-rater reliability reported for any of the monitoring tools, which would be necessary to ensure consistency in monitoring and be one measure of the validity of the results. ▪ 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 provisions. For example, at times, without citing a standard, such as a nursing protocol, it was unclear what criteria had been used to determine compliance. 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 substantial compliance with none of the subsections of Section M. This was consistent with the Monitoring Team's findings. 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 some turnover in the key nursing leadership positions. Due to these staffing issues, the Facility had to continue to use 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 June 2013, the Nurse Operations Officer position was filled; ▪ In August 2013, a Nurse Educator position was added and filled; ▪ In September 2013, an Infection Control Nurse was hired; ▪ In October 2013, the Hospital Liaison position was filled; and ▪ In November 2013, a Quality Assurance Nurse was filled. At the time of the review, some of the leadership positions noted above had only recently been filled. This had resulted in a number of promising systems that previously had been implemented not being maintained, because none of the new nursing leadership staff had any overlap with their predecessors. Some examples of such concerns included: the infection control systems; consistency in medication refill/count procedures warranting the need to implement a 24-hour count; the medication identification process; hand-washing auditing; gaps in data and lack of formal processes in place to trend and analyze the data that had been generated; the regression found in the documentation contained in the integrated health care plans, the nursing assessments, and documentation in response to changes in status; and the regression in the quality of the quarterly and annual Comprehensive Nursing Assessments as noted in the findings related to Sections M.1, M.2, M.3, and M.5. However, some of the Facility's positive steps forward included: ▪ The data indicated that of all of the 111 (100%) total emergency drills that were conducted were deemed as passing, which was a very positive finding. ▪ The Monitoring Team's review of the Facility's data verified that the required daily emergency equipment checks Risk Management staff and nursing staff completed were consistently being conducted. ▪ The Facility took aggressive action to address an ongoing outbreak of Clostridium difficile (C-Diff) that had not been adequately identified and systematically addressed for several months. The Facility had put together a very comprehensive Presentation Book that included specific and detailed information regarding what actions were taken both on a systemic level as well as on an individual level. In addition, the Facility brought in an Infectious Disease physician who provided clinical expertise to the Facility regarding isolation strategies as well as treatment recommendations. Facility staff's presentation of this issue to the Monitoring Team at the beginning of the review week demonstrated that the Facility had taken an integrated approach to a very challenging and serious health issue that ultimately benefited the individuals as well as the staff at the Facility. While 19 individuals were involved in the outbreak, at the time of the review, no individuals were experiencing symptoms of C-diff. ▪ On a very positive note, regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated there had been 19 individuals who had an incident of an acute infection: C-Diff. Of the 19 incidents, all individuals (100%) were found to have had Care Plans addressing the infectious issue. Of the 19 Nursing Care Plans reviewed, 16 were found to be clinically adequate (84%). ▪ The pharmacy continued to conduct spot checks audits of the Medication Administration Records and the medication rooms across all the residences.

	Although the Facility had made some positive steps forward in the areas noted above, there continued to be an overall lack of progress, and in some areas, significant regression, found regarding the infection control program, the integrated health care plans, the nursing assessments, documentation in response to changes in status, and the quality of the quarterly and annual Comprehensive Nursing Assessments. Unfortunately, the challenges in stabilizing the nursing coverage related to staff turnover had continued from the last review, and the significant changes made in the nursing leadership positions since the last review had prohibited the Facility from making progress in many of the crucial areas affecting individuals' healthcare.

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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 Facility indicated that as of November 2013, 204 of 204 (100%) individuals and 100% of the staff were current with their Tuberculosis screenings. In addition, 192 out 204 (94%) individuals had received their Flu vaccines. ▪ Consequently, due to the significant lack of information contained in the Facility's Self-Assessment addressing the requirements for M.1, the Monitoring Team was not able to consistently ascertain what specific activities the Facility was conducting to review its progress regarding this requirement of the Settlement Agreement. ▪ However, of special note, the Presentation Book for Section M was noted to be impeccably organized and comprehensive. <u>Self Rating</u> The Facility's Self-Assessment indicated that: "based on this self-assessment, this Provision is not in substantial due 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	Noncompliance

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		had continued to experience major staffing challenges, that included as of November 2013, an average nursing turnover rate of 26.67% for Registered Nurses (RNs) and 58.54% for Licensed Vocational Nurses (LVNs). In addition, the Department experienced a significant turnover in RN Case Managers (RNCMs) since the last review that included a turnover rate of 44% (seven out of 16) with two RNCMs on leave. The Chief Nurse Executive indicated that recruitment efforts had consisted of advertising in local newspapers, the Texas Board of Nursing Bulletin, and on local radio stations, along with participation in job fairs, and initiation of contact with local nursing schools. In addition, regarding retention efforts, in August 2013, the Facility developed and implemented, a new nursing mentorship program to promote, encourage, and motivate new nursing staff. Also, the Nursing Praise program was implemented to improve moral and motivation. Interviews with the CNE and the Program Compliance Nurse indicated that since the last review, due to staff vacancies, there had been periods of time where very few monitoring activities had been conducted, resulting in little to no data generated addressing some of the requirements of the provisions for Section M. Although very little data was contained in the Self-Assessment for Section M, it was evident from the data that was presented 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. As noted in previous reports, 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 how to analyze their data to identify problematic trends. <u>Staffing</u> At the time of the review, LBSSLC had a census of 202 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: ▪ In June 2013, the Nurse Operations Officer position was filled; ▪ In August 2013, a Nurse Educator position was added and filled; ▪ In September 2013, an Infection Control Nurse was hired; ▪ In October 2013, the Hospital Liaison position was filled; and ▪ In November 2013, a Quality Assurance Nurse was filled. In addition, at the time of the review, the information provided in the Self-Assessment indicated that the Nursing Department had a total of 102 allotted positions. The nursing vacancies included nine RN positions and eight 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 and continued to regularly warrant the use of Agency nurses to cover shifts on a daily basis. Data addressing staffing that was provided in the Facility's Self-Assessment indicated that the fill rate for	

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		the various nursing positions were as follows: ▪ LVN III – 85.2%; ▪ LVN II – 0%; ▪ RNIV – 80%; ▪ RN III – 96.2%; and ▪ RN II – 54.4%. In addition, at the time of the review, some of the leadership positions noted above had only recently been filled. This had resulted in a number of promising systems that had been previously implemented not being maintained, because none of the new nursing leadership staff had any overlap with their predecessors. In addition, these practices had not been firmly established in policy and procedure to facilitate their continued implementation even with staffing changes. 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 had turnover in the Quality Assurance Nurse positions. In August 2013, an auditing process was established for the QA Nurses and the Program Compliance Nurse that included the following: ▪ Every month QA selected a random sample from the high-risk database for the Nursing and the QA Nurses to audit; ▪ Nursing was to audit 5% and QA was to audit 3% of the nursing protocols addressing urinary tract infections, Enteral feeding intolerance/complication, respiratory distress/aspiration, and constipation; ▪ In addition, Nursing was to conduct four audits and QA was conduct two audits addressing Urgent Care/ER/Hospitalization, Annual Assessment, care plans, and infection control; ▪ Nursing also was to randomly audit protocols, and the quality of nursing assessments and care plans; and ▪ At the time of the review, the database for data entry had not been established. The Facility indicated that it was working with a data analyst to create a database that would facilitate trending and analyzing the data. Although the Facility indicated that the Department developed and implemented a promising process to review the nursing documentation for individuals that had been hospitalized using the nursing protocol cards, a review of the raw data generated from the Nursing Chart Review process found that the review only included the reactive use of	

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		nursing protocols addressing nursing assessments, and not the use of the protocols regarding existing health issues that warranted regular, proactive nursing assessments. Consequently, the current format of the Nursing Review audits were concerning to the Monitoring Team in that they did not lend to generating an adequate and accurate review of the quality of the clinical care and treatment that individuals received. As a result, the data were not in alignment with the findings of the Monitoring Team noted in the section below. However, if the Facility modified the Nursing Review audit form to include a proactive review of the use of nursing protocols, the data generated would more accurately reflect the current nursing practices and clinical care provided to the individuals. In addition, the monitoring tool needed to have specific instructions addressing how the quality of the documentation was to be determined, such as using the nursing protocols proactively as well as reactively as the standard for determining compliance. At the time of the review, the Program Compliance Nurse and the CNE indicated that much of the data that had been generated from the QA Nurses, the Nursing Department, and the Program Compliance Nurse since the last review had not yet been trended and formally analyzed due to issues related to the databases. In addition, it was unclear to the Monitoring Team where the Facility was in the process of establishing inter-rater reliability for each of the auditing tools currently being used to monitor nursing issues. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> A review of nine individuals' IPNs (i.e., Individual #76, Individual #43, Individual #317, Individual #233, Individual #74, Individual #211, Individual #284, Individual #308, and Individual #165) 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 individual's 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 alignment with the	

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		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 nine individuals found basically the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past reviews. 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 guide their assessments and/or documentation. The result of the lack of regular nursing assessments conducted for existing medical issues was the consistent lack of recognition that the symptoms the individuals were experiencing were signs of changes in status. The lack of consistent nursing assessments found in the documentation made it largely impossible to accurately determine exactly when changes in status were initially occurring. The case of Individual #230 as detailed with regard to Section M.4 was a tragic example of the existing deficits regarding the use of nursing protocols to guide nursing assessments and care. Although some IPNs were found that contained adequate nursing assessments, the lack of consistency of these nursing assessments rendered the overall care of the individuals inadequate in addressing 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. Due to the number of individuals with complex medical needs at LBSSLC, this area should be considered a high 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. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that very few documents were missing from the active records. However, 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	

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		when making decisions regarding treatments and health care services <u>Infection Control</u> Since the last review, there had again been turnover in the Infection Control Nurse position. The position had been vacant from February through May 2013, then filled in June 2013. It was again vacant in August 2013, and then filled again in September 2013. Consequently, many of the systems that had been established and implemented had not been maintained throughout the period of time the position was vacant. Unfortunately, this had resulted in the loss of some positive progress in this area 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 differences regarding the infection control data to ensure that the data were reliable. Discussions with the Infection Control Nurse and CNE indicated that the available IC data regarding acute infections that occurred since the last review most likely were not reliable. Without data reliability, any identification of trends and analysis of IC practices is conjecture at best. ▪ Although the Facility had reported during the past review that the Immunization database was completed, the IC Nurse indicated that the historical data was being gathered and entered into the immunization database. However, at the time of this most recent review, the Facility could not determine which individuals' immuniztion status had been researched and updated as appropriate. Thus, there was no indication of progress regarding the tracking, trending, and analysis of these data at the time of the review. 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 in October 2013, the Infection Control Committee was resurrected, little to no information was included in the minutes, dated 12/23/13, to show 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. Such analyses are necessary to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. ▪ 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 Infection Control Committee meeting minutes. ▪ At the time of the review, the Infection Control nurse was not conducting any	

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		Environmental Surveillance Surveys, although Risk Management was currently conducting them. However, no trending or analysis of this data was found in the Infection Control Committee meeting minutes. However, some very positive movement forward was noted in the following areas: ▪ In spite of the lack of structure in the Facility's current IC program, the Facility took aggressive action in addressing an ongoing outbreak of C-diff that had not been adequately identified and systematically addressed for several months. The Facility put together a very comprehensive Presentation Book that included specific and detailed information regarding what actions were taken both on a systemic level as well as on an individual level. In addition, the Facility brought in an Infectious Disease physician who provided clinical expertise to the Facility regarding isolation strategies as well as treatment recommendations. The Facility staff's presentation of this issue to the Monitoring Team at the beginning of the review week demonstrated that the Facility took an integrated approach to a very challenging and serious health issue that ultimately benefited the individuals as well as the staff at the Facility. While 19 individuals were involved in the outbreak, at the time of the review, no individuals were experiencing symptoms of C-diff. ▪ On a very positive note, regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 19 individuals had had an incident of an acute infection: C-Diff (i.e., Individual #100, Individual #43, Individual #225, Individual #161, Individual #176, Individual #171, Individual #196, Individual #191, Individual #139, Individual #324, Individual #128, Individual #323, Individual #226, Individual #312, Individual #6, Individual #293, Individual #89, Individual #283, and Individual #269). Of the 19 incidents, all individuals (100%) were found to have had Care Plans addressing the infectious issue. Of the 19 Nursing Care Plans reviewed, 16 were found to be clinically adequate (84%). The individuals' Care Plans that were not clinically adequate included: Individual #128, Individual #283, and Individual #269 (the discussion related to Section M.3 includes specific details of these findings). Since the Monitoring Team's last review, the regression noted in the area regarding Infection Control was of serious concern. Many of the steps forward regarding Infection Control that had been found during the past reviews had not been maintained. At the time of this review, LBSSLC was in the process of rebuilding the infrastructure of its IC program. The Facility had much work to do regarding building enduring systems 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.	

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		Mock Code Drills and Emergency Response Systems Since the last review, LBSSLC indicated the following steps were initiated regarding this area: ▪ Since the last review, the Facility continued to conduct the required number of Emergency drills. ▪ The CTD staff continued to present a weekly report of the Emergency drills to the Incident Management Committee. The data indicated that all of the 111 (100%) total drills 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 Risk Management staff and nursing staff completed were consistently being conducted. ▪ At the time of the review, the Facility was in the process of re-establishing inter-rater reliability for the Emergency Drill tool due to turnover in the QA Nurse positions. ▪ Although there was a gap in November 2013 due to staffing issues, the QA Nurse resumed conducting the emergency equipment drills for nursing right after the Emergency Drills were conducted. ▪ There were no indications from the information contained on the Emergency Drills that there were incidents of staff resistance regarding participation in the Emergency Drills since the last review. ▪ At the time of the review, the Facility had a total of 21 Automated External Defibrillators (AEDs) with plans to possibly purchase two to three more for the Chapel and the Administration building. Unlike the Monitoring Team's findings from the previous review, the CNE and Nurse Educator were fully aware of the total number of AEDs at the Facility and where each of them was located. The Facility clearly had implemented some positive steps addressing the Emergency Response System. However, some problematic issues were still found that should be addressed in order for additional progress to be made: ▪ The Nurse Educator reported that the Emergency Equipment Competency Checklist that should be conducted at least every quarter for each nurse had not been regularly conducted due to staffing issues. ▪ As noted from past reviews, no clinical review was conducted of the Mock Code Drills as well as 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. Given the significant findings regarding the delays that were reflected in the documentation regarding the emergency response for Individual #230 as discussed in detail with regard to Section M.4, a clinical review of this tragic case would have been essential in	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>identifying the actual and potential barriers in accessing emergency responses in order to promptly implement any needed corrective actions.
▪ The Monitoring Team's observations of nurses demonstrating the emergency equipment at Rose and Zinnia found that although the staff were more familiar with the emergency equipment than at the last review, staff had not been routinely turning on the AEDs during their emergency checks, and thus, when asked to do so were hesitant or unsure of exactly how to turn on the AED. This had the potential to be a significant barrier to treatment in the case of a real emergency. In addition, a number of pieces of back-up equipment, such as oxygen tanks and suction machines, had not been checked and documentation that they were in good operational condition was not found.

Although the Facility had made some positive steps forward regarding LBSSLC's Emergency Response System, there continued to be some significant problematic issues regarding the use of the Facility's emergency equipment.

Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.</td><td></td></tr>
<tr><td>M2</td><td>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.</td><td>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's Self-Assessment indicated that 14 out of 16 (88%) Registered Nurse Case Managers (RNCMs) had been trained regarding the Annual and Quarterly Assessment guidelines and new forms.
▪ In addition, the Self-Assessment indicated that, as noted below, the Facility found conflicting data generated from the RNCM Supervisor and Quality Assurance Department regarding the timeliness of Nursing Annual Assessments. Although the Facility indicated that a corrective plan of action was developed to improve the timely submissions of the Nursing Annual Assessments, no information was contained in the Facility's Self-Assessment addressing how the significant discrepancies between the two data sets was resolved to ensure that the data going forward were reliable. Also, the data presented in the Facility's Self-Assessment did not include the population (N) and sample size (n) in order to yield a percent sample size.

The Facility Self-Assessment reported data from the QA Department:

<table><tr><th>May</th><th>June</th><th>July</th><th>August</th><th>September</th><th>October</th></tr></table></td><td>Noncompliance</td></tr>
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Annual Nursing	17%	38%	69%	33%	63%	41%	

The Facility Self-Assessment reported data from the RNCM Supervisor:

	May	***June***	***July***	***August***	***September***	***October***
Annual Nursing	94%	88%	88%	94%	100%	88%

- The Facility indicated that a review of the timeliness of the Quarterly Nursing Assessments found the following:

	May	***June***	***July***	***August***	***September***	***October***
Quarterly Nursing	77%	98%	83%	85%	93%	98%

However, again, the data presented in the Facility's Self-Assessment did not include the population (N) and sample size (n) in order to yield a percent sample size for each month in order to determine the relevance of the data.

- The Facility's Self-Assessment noted that at the time of the review, no formal process had been initiated to monitor the quality of the nursing assessments. However, the Program Compliance Nurse indicated that she had informally begun reviewing these monthly, as well as incorporating the review of the nursing assessments in the nursing record audits for hospitalizations. Although this process had positive potential, the lack of appropriately defined criteria/standards regarding what constituted compliance regarding the quality of the nursing assessments rendered the data generated from these reviews unreliable.
- In addition, the Facility indicated that 14 out of 16 (88%) RN Case Managers received training regarding "discharge instructions." However, the information contained in the Presentation Book for Section M only indicated that a training session was held, but did not include the content that was presented. Although the Self–Assessment noted that of the five individuals that had transitioned to the community since the last review, "discharge summaries for all 5 individuals were completed," the Monitoring Team found from its review that the quality of these discharge nursing assessments were poor (specific details are discussed below).

<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 needs improvement. Action Plans are in place to address these needs."

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		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, the Nursing Department had made inconsistent progress in addressing most of the provisions of the Settlement Agreement. However, as noted during previous reviews, it was concerning to the Monitoring Team that thus far, 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. Also, the lack of implementation of the nursing protocols had resulted in the lack of relevant nursing assessments being conducted on the individuals, and therefore, objective clinical data was not even generated during the past several quarters to allow analysis to occur. As a result, the Monitoring Team continued to find the Facility's Comprehensive Nursing Assessments to be clinically inadequate, and in fact, they contained less relevant clinical information than found in past reviews. 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 #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues: ▪ Of the 23 individuals' nursing quarterly assessments reviewed, 23 (100%) were timely completed. ▪ 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. In a number of the nursing assessment summaries reviewed, there was no mention of some or all of the medium and/or high health risk indicators. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed.	

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		Consistent with the findings from the previous reviews, the Monitoring Team found that there had been no progress made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. From the Monitoring Team's review, 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 regarding improving the quality of the nursing assessments that were noted to be "in progress," at the time of the review, it was unclear how the Nursing Department actually planned to address this issue. Interviews with nursing leadership during the review appeared to indicate that there was an increase in understanding regarding the use of the Nursing Protocols in guiding nursing assessments and the associated nursing documentation. However, 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. 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. As noted in previous reports, this area should be considered a priority for nursing. It is imperative that the 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/mental health status. A review of the nursing documentation and Nursing Discharge Assessment Summaries for six individuals discharged/transitioning to the community (i.e., Individual #64, Individual #61, Individual #291, Individual #81, Individual #79, and Individual #19) found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. None of the IPNs were included in the document request that stated: "For the past six months, nursing documentation for individuals who have transitioned to the community,	

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		including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. 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. A review of the Facility's Action Plan addressing Discharge Summaries indicated that training had been provided to the Case Managers regarding "content needed for Discharge Summaries." However, as noted previously, no information was provided describing the training or content of the training. In addition, no improvement was found in the nursing documentation for the individuals that had been transitioned to the community since the last review, calling into question the quality of the training. 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 in November 2013, monitoring for nursing care plans had been implemented. However, no data addressing this area was provided in the Self-Assessment. In addition, the Facility reported that the Chief Nurse Executive completed a random review of 11 Acute Care Plans and found adequate individualization, proper interventions, goals, and direct support professional instruction in 11 of 11 (100%). However, no information was provided regarding the specific criteria constituting compliance. As noted below, the Facility's findings were not in alignment with the findings of the Monitoring Team. Also the Facility's Self-Assessment indicated that monitoring was implemented in August 2013 regarding the timely completion and implementation of the Integrated Health Care Plans. However, the data presented was uninterpretable, because no information was included addressing what exactly the compliance scores represented, the sample size, and the specific criteria defining compliance. Also, 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. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "based on this self-assessment, this provision is not in substantial compliance as IHCP with lack of monitoring and trending with	Noncompliance

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		corrective actions taken [sic]." Although the Facility's finding of noncompliance was consistent with the Monitoring Team's finding, the specific reasons why the Facility found this requirement not in compliance were not clear. The records of 23 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues. Of the 23 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Twenty-two (96%) were found to have a care plan addressing their high or medium risk health/mental health indicator. The individual who did not have a related care plan was Individual #23. ▪ None (0%) of the nursing interventions contained in the 22 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 22 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 22 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 22 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 22 care plans, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. Although at the time of the review, the Facility was in the process of working to improve their overall ISP process that included the development of Integrated Health Care Plans, it was very concerning to the Monitoring Team to note the overall lack of progress in this area since the last review. Specifically, some of the problematic issues identified in the	

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		Facility's previous care plans were found in the current IHCPs including: ▪ The rationale for several risk levels on the Integrated Risk Rating forms did not consistently include the needed clinical justification to support the designated level. Consequently, it was often difficult for the Monitoring Team to determine the accuracy of some of the risk levels and the need for action steps addressing the health risks. ▪ Many of the goals listed in the IHCPs did not address the etiology of the health problem as an objective clinical area of focus to assist the team in developing action steps that were individualized. Consequently, many 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. ▪ As noted above, none of the nursing action steps found in the IHCPs reviewed 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 did not consistently 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. Unfortunately, many of the nursing action steps were noted to be meaningless in that they were often generic, not measurable, 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 many of the action steps prohibited validation that the steps were actually being implemented. It is imperative that the Facility address the lack of clinically adequate care plans for the individuals under their care regardless of the system and system changes made to the Facility's overall plans of care. As previously recommended, the Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at LBSSLC. Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 19 individuals had had an incident of an acute infection: Clostridium difficile (C-Diff) (i.e., Individual #100, Individual #43, Individual #225, Individual #161, Individual #176, Individual #171, Individual #196, Individual #191, Individual #139, Individual #324, Individual #128, Individual #323, Individual #226, Individual #312, Individual #6, Individual #293, Individual #89, Individual #283, and Individual #269).	

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		▪ Of the 19 incidents, 19 (100%) were found to have had Care Plans addressing the infectious issue. ▪ Of the 19 Nursing Care Plans reviewed, 16 were found to be clinically adequate (84%). The individuals' Care Plans that were not clinically adequate included Individual #128, Individual #283, and Individual #269. Clearly, the efforts between the IC Nurses and other nurses within the Nursing Department resulted in an increased number of clinically appropriate Care Plans addressing the infectious illness, C-Diff. Although clearly, some positive progress was noted in the clinical content contained in most of the IC Nursing Care Plans reviewed, additional work was needed to further individualize the template used regarding C-Diff to consistently specify how often assessments should be conducted, who will be conducting the assessments (i.e., the RN or LPN), where they will be documented, and who and how often the documentation will be reviewed. From the Monitoring Team's review, these elements were not consistently included in the IC Care Plans. The Nursing Department needs to guard against falling back into the practice of purely using templates as Care Plans without appropriately individualizing the clinical content. Nursing Administration, in conjunction with the Infection Control Nurses need to continue efforts to develop and implement systems 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/Nursing Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ Be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. 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	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 Facility reported that the Nurse Educator position was filled in September 2013, and new Nurse Educator attended a nurse educator workshop addressing the Nurse Orientation process. In addition, the Facility indicated that as of	Noncompliance

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	served.	November 2013, 37 out of 46 (80%) RNs completed the Physical Assessment class, and 68 out of 84 (81%) nurses completed the medication administration class. Also, 48 out of 84 (57%) nurses had completed the Annual Competency training. Although the training was a positive step, it was not clear to the Monitoring Team how these trainings addressed this particular provision. ▪ Although the Facility indicated that a Nursing Chart Review process to review documentation using protocol cards was implemented, no data were presented in the Self- Assessment. However, the Monitoring Team's review of the raw data regarding the Nursing Chart Reviews found that the Facility was only reviewing the reactive use of the nursing protocols, and not the use of nursing protocols for existing medical issues. Consequently, the data generated from these reviews were not in alignment with the findings of the Monitoring Team. ▪ The Facility reported that seven administrative death reviews were completed between May and October 2013, with the recommendations generated tracked through the IMRT. However, no additional information was provided to indicate how this process was related to this specific provision. <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 changes being implemented in order to achieve compliance." Although the Monitoring Team found some mention of nursing protocols in a few of the IHCPs it reviewed, all of the nursing assessments listed in the nursing protocols were included in the plans for implementation only after an acute health event occurred. Instead, they should be used proactively for individuals with known high and medium health risks to attempt to prevent the occurrence of an acute health event. In essence, using nursing protocols only reactively indicates that an individual has to become ill in order to be provided regular nursing assessments in alignment with the protocols and only for as long as the acute event persists. Consequently, only implementing nursing protocols reactively does not result in improved clinical care focused on minimizing health risks. Unfortunately, at the time of the review, the increased reactive use of nursing protocols found in some of the IHCPs did not result in an improvement in clinical care. Many of the same significant problematic issues were found for the current review regarding nursing assessments, care plans, and the overall nursing care, as well as the associated documentation as was found during the previous reviews. Specifically, although some limited progress was seen, the 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	

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		plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility was not implementing nursing protocols sufficiently 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 #230's health care prior to his unexpected death from a subdural hematoma in October 2013. Based on the documentation the Facility provided identifying risk ratings, Individual #230 was noted to be at high risk for dental issues, cardiac disease, falls, fractures, and at medium risk for respiratory compromise, gastro-intestinal issues, constipation, osteoporosis, and behavioral issues. Information contained in the IRRF, dated 2/14/13, indicated that the individual had sustained a fall on 5/18/13, resulting in a fracture to his right shoulder. In addition, the IRRF indicated that: "Trends and patterns noted he had several falls due to gait issues." However, no specific information, such as the number of falls and the dates they had occurred, was provided. He also was noted to have high blood pressure, hyperlipidemia, and hypertriglyceridemia. 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 #230, the Facility indicated that: "As per this request there is no IHCP available. [Individual #230's] ISP occurred in 2/2013 and the IHCP process was implemented in 3/2013." Consequently, no documentation addressing his care plans was provided to the Monitoring Team. ▪ In addition, in spite of the fact the IPNs indicated that he had skin issues and was being seen at the Skin Wound Clinic, the Facility indicated that: "As per this request and per chart review there are no ACP's [acute care plans] present for [Individual #230]." ▪ The summary sections of the Comprehensive Nursing Assessments, dated 4/5/13 and 7/18/13, did not include an analysis regarding the individual's health risks. The summary section of the Quarterly Nursing Assessment, dated 7/18/13, merely stated: "Individual #230 is in fairly good health. He didn't have any problems this quarter." This was despite the fact he had experienced the acute event of sustaining a fracture in May 2013. ▪ There were discrepancies noted throughout the IRRF regarding whether or not Individual #230 actually had diabetes. Some of the documentation clearly indicated that he did have diabetes, which was noted on the IRRF to increase his risk for skin problems. However, under the Diabetes risk factor, the IRRF noted: "Individual #230 previously had a diagnosis of diabetes. This has changed. Per Endocrinologist, Individual #230 does not have diabetes per chart review."	

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		▪ The IPNs reviewed contained no consistent and regular nursing assessments to establish baselines in alignment with the nursing protocols. Given this individual's medium and high risk factors, consideration should have been given to establishing baselines to promptly identify changes regarding physical assessments, mental status, daily activities, status of gait, skin assessments, vital signs, lung sounds, oxygen saturations, bowel sounds, abdominal palpation, daily food, and fluid input. ▪ The IPNs on 9/24/13 from nursing indicating that Individual #230 was found on the floor in his bedroom after nursing heard a thump, and he had redness to his right shoulder and knee. Aside from vital signs, no other nursing assessment was found in the documentation provided regarding the individual's mental status, or neurological checks. In addition, no nursing follow-up assessments were conducted and documented in spite of the fact that the nurse's note stated nursing would continue to monitor for any injuries regarding bruising or swelling, and the physician's note, dated 9/26/13, indicated that the individual had a bruise at the right occipital area and noted to "monitor for head injury." ▪ There was no indication that the physician was notified at the time of the incident on 9/24/13. ▪ The QIDP note, dated 9/27/13, indicated that Individual #230 had two falls on 9/24/13 that resulted in a bruise to his left buttocks and the back of his head on the left side, which was not found in the documentation in the IPNs on 9/24/13. The noted concluded with "current supports effective." ▪ No regular nursing assessments were documented in the IPNs regarding skin lesions and a venous ulcer to the individual's lower legs. ▪ The nursing IPN, dated 10/10/13, at 1200 indicated that while at an appointment, clinic staff had discovered a laceration to the individual's right lower extremity that required four sutures indicating that there possibly had been an unwitnessed injury or fall. In addition, the same IPN indicated that the direct support professional reported that the individual had one episode of emesis. Although vital signs were recorded at the time, given the circumstances of a possible fall and vomiting, a baseline nursing assessment including his mental status, cognitive functioning, and neurological checks should have been obtained with follow-up nursing assessments conducted during the day. However, no documentation of any such assessments was found. ▪ The initial IPN on 10/10/13 at 1515 indicating that there had been a change in Individual #230's status stated that: "he was very out of it," and included a set of vital signs. However, it did not include any type of assessment of the individual's mental status or neurological checks. In fact, it was not clear whether a nurse had written this IPN, because the section marked "Discipline" was left blank. Although the IPNs on 10/10/13 at 1515 and 1615 indicated a number of nurses were present, no IPNs were found documenting a comprehensive nursing assessment of	

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		the individual's status. ▪ The nursing IPN on 10/10/13 at 1630 indicated that the individual's feet were gray, ashy looking, and cold, and he was flaccid in all extremities and his eyes were fixed and dilated. In addition, the note indicated that he had been "unresponsive for some time," and had no response to nail bed pressure. Although the note indicated that a nurse on the scene was told to obtain "constant vital signs," no additional nursing assessments were documented in response to the description of the individual noted above. In addition, the note indicated that the nurse: "asked three separate times when EMS [Emergency Medical Services] was called," to another nurse at the scene, and on the third request the nurse was told: "they were working on it." ▪ There were no IPNs found documenting the individual's status at the time he was transported to the hospital. ▪ The subsequent IPNs on 10/11/13 at 1515, 1540, 1600, and 1630 were extremely confusing and contained a number of late entries that made it difficult to chronologically follow the sequence of events that took place prior to Individual #230 being sent to the hospital at what appeared to be 1645 on 10/10/13. A review of these IPNs portrayed a chaotic situation with a number of staff members mainly documenting what other staff members were doing rather than describing Individual #230's status at the time. In addition, there were significant discrepancies found in the IPNs regarding the individual's status. The nursing IPN on 10/10/13 at 1630 indicated that the individual had been "unresponsive for some time." The late entry IPN on 10/11/13 at 1540 indicated the staff had reported that the Individual had been nonresponsive for "the last hour or so," while the IPN on 10/11/13 by the QIDP (untimed) indicated that staff reported the individual was "unresponsive to her all afternoon." In addition to these discrepancies in documentation, the underlying concern was the possibility that there was a delay in the reporting the individual's change in status to nursing and medical staff, resulting in a delay in treatment. ▪ In addition, the documentation the Facility provided indicated there had been a delay in the Facility Operator calling EMS, because the designated phone for 3733 (emergency calls) had not been used. However, from the documentation provided, the Monitoring Team was unable to determine how long of a delay actually occurred. ▪ Although the information from the hospital mortality list indicated Individual #230 died on 10/11/13, no IPN was found documenting the individual had been pronounced dead at the hospital. Also, a review of an additional nine individuals that were admitted to the hospital since the last review (i.e., Individual #76, Individual #43, Individual #317, Individual #233, Individual #74, Individual #211, Individual #284, Individual #308, and Individual #168)	

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		found similar problematic issues throughout the nursing documentation as those found in Individual #230'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 the Settlement Agreement requires. 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: ▪ 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's Self-Assessment indicated that since the last review, the At-Risk Individuals procedure was revised and finalized. The Facility's Self–Assessment indicated that a review of the training data for the Individual Support Plan – At-Risk Individuals procedure demonstrated that of the 425 staff identified as needing trained, 365 staff (86%) received the training. In addition, data from the QIDP Coordinator's ISP attendance tracking indicated that for May through October 2013, compliance rates for nursing attendance was 94%, 94%, 100%, 100%, and 100%, respectively. However, no other additional information was provided addressing this requirement in the Self-Assessment for Section M. <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," which was the same Facility	Noncompliance

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		finding as from the previous review. Consistent with past reviews, the findings from the Monitoring Team noted below indicated the documentation reviewed did not adequately address individuals' health/mental health 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 #23, Individual #179, and Individual #167 for behavior issues; Individual #127, Individual #147, and Individual #235 for cardiac issues; Individual #284, Individual #170, and Individual #70 for constipation; Individual #52, Individual #312, and Individual #309 for falls; Individual #300, Individual #204, and Individual #320 for weight issues; Individual #8, Individual #90, and Individual #100 for urinary tract infections; Individual #192, Individual #104, and Individual #283 for gastrointestinal issues; and Individual #84 and Individual #80 for circulatory issues) found that none (0%) included an adequate nursing risk assessment that included individual-specific information that clearly justified the risk ratings assigned. 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. 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, based on a review the sample of 23 records for individuals determined to be at risk, there was documentation that the Facility:	

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		▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Although all 23 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, none (0%) sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 23 Integrated Health Care Plans 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 IHCPs addressing, for example, the need to encourage compliance with a healthy diet and encourage adequate fluids and exercise, 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 23 of the 23 cases (100%). ▪ 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 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	

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		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 as of November 2013, 86 of 102 (84%) nurses had completed Medication Administration Class (which was noted to be different than the data the Facility reported in the Self-Assessment for Section M.4), and from May through October 2013, RN Unit Mangers conducted 86 of 86 (100%) medication administration observations with 84 of the 86 (98%) passing. Of the two failed observations, the Presentation Book documentation indicated that appropriate immediate corrective action taken was taken in both cases. However, there was no indication as to how many medication administration observations should have been conducted, because information obtained from the Quality Assurance Nurse indicated that since the last review, not all of the required medication observations were completed due to staffing issues. Although a the Medication Administration Observation spreadsheet was included in the Presentation Book, there were no numbers (N and n) included to indicate how many of the required Medication Observations were actually completed since the last review. A list of names on a spreadsheet, especially given the significant number of staffing changes the Facility reported took place since the last review, was meaningless data to address this issue. ▪ Although the Facility indicated that Medication Room Surveys were being conducted at each home from May through October 2013, no data was provided in the Self-Assessment regarding the findings or corrective actions taken regarding these surveys. ▪ In addition, the Self-Assessment indicated that a random sample of 11 Medication Administration Records (MARs) was reviewed, and the reviews found that all (100%) included a Physical Nutritional Management Plan. Also, a review of 30 medication identification (ID) card audits from August through October 2013 found that although 100% of nurses used the medication ID cards to identify the individual receiving medications, three medication errors related to the right person had occurred. The Facility indicated that: "it appears increased monitoring and development of CAP process is needed when this occurs." However, no additional information was provided in the Self-Assessment indicating if further monitoring and corrective actions were actually implemented. ▪ The Facility indicated that starting in March 2013, all unexplained returned	Noncompliance

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		medications were now being considered a dose omission accompanied by a variance report. Also, in August 2013, the Facility began counting the unreturned medications as doses rather than individual units or number of pills in alignment with the State Office policy. The Facility reported that from May through July 2013, 3363 units (number of pills) of medication were returned to the pharmacy as unexplained. From August through October 2013, there were 358 unexplained doses that were returned. Thus, by changing the way the returned medications were tallied, the raw numbers of returned medications appeared to look significantly lower. However, at the time of the review, the Clinical Pharmacist indicated that there was not a significant decrease in the overall unexplained returned medications as might be erroneously interpreted with the change in how the returned medications were being counted. ▪ Although the Facility's Self-Assessment indicated that data for the number of returned medications was available by month, by home, 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. <u>Self-rating</u>: Regarding the Facility's compliance rating, the Self-Assessment stated: "based on this self-assessment, this provision is not in substantial compliance due to lack of improvement with unexplained returned medications. Action Steps are in place." The Monitoring Team's findings supported the Facility's Self-Rating of noncompliance regarding this provision. However, due to the lack of information in the Self-Assessment, it was unclear to the Monitoring Team what the Facility's specific findings were from its trending and analyses activities. Additional information would have been helpful 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 essential requirement of the Settlement Agreement. From interviews with the Nursing and Pharmacy Departments and review of the minutes of the Medication Safety and Systems Committee, the following steps regarding the Facility's overall medication administration system had been initiated: ▪ In August 2013, the Facility initiated a new medication refill process to guide the nursing staff in the proper refill procedures to ensure the safety of medication pass in each home. ▪ In September 2013, a new position, Medication Refill Nurse, was created and implemented to complete all medication refills in order to decrease the amount of errors and facilitate better data trending. However, "Meeting Minutes" dated	

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		11/7/13 found in the Presentation Book indicated that this position "would no longer be refilling medications." Also, the results of the Medication Administration Observations began being discussed at the regular Nursing Staff meetings. ▪ At the time of the review, the two residences (Canna and Aspen) that consistently had the most medication variances had just begun a pilot refill process that included refilling medications for 24 hours at a time in order to monitor any excess or shortages in medications on a daily basis. ▪ On a very positive note, at the time of the review, the Facility had begun to address the type of medications that were being returned to the Pharmacy in order to identify any emerging clinical issues due to the unexplained returned medications regarding constipation, seizures, and physical or chemical restraint use. ▪ The Pharmacy Department had continued to conduct spot checks audits of the Medication Administration Records and the medication rooms across all residences. 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 refills every 24-hours for two residences that had the most medication variances, nursing staff had not consistently implemented previous processes that had been initiated, such as conducting medication counts between shifts to timely identify excess or shortages of medications. Consequently, the Facility indicated that these past strategies made little to no impact regarding the number of unexplained excesses and/or shortages of medications. ▪ As noted during past reviews, the Facility had identified the lack of consistent nurses assigned to specific residences as well as the use of Agency nurses due to staffing issues as factors resulting in increases in medication variances. However, there was no indication that a plan or procedure was developed and implemented addressing these situations, especially with the consistent staffing challenges the Nursing Department experienced. The information in the Presentation Book related Unit I staffing and Unit Guidelines described staffing procedures addressing absences/vacation/call-ins; floaters; and agency use; and noted that: "as of December 2, 2013, Unit I will officially close." The document stated that this should "promote continuity of care of the individuals and that staffing assignments will be consistent and is also being implemented to promote accountability in our nursing staff, promote better documentation and supervision of staff nurses by the unit managers." However, there was no indication that consistent staffing actually had been implemented. In fact, the Facility reported that they were still having	

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		problems filling the vacancies and were using agency nurses. In addition, the number of unreconciled medications remained high. Although it appeared the Facility had developed a plan to address the need to assign consistent nurses, evidence was not presented to show the plan had been implemented. In addition, the Monitoring Team would have expected the Facility to increase the medication observations, and MAR blank spot checks for the areas where they had the most inconsistent staffing. ▪ The Facility had previously implemented a positive system to decrease medication variances due to medications being given to the wrong individual. This system included using laminated identification cards with each individual's picture to accurately identify individuals when administering medications. However, from the Monitoring Team's medication administration observations in Quail, this process was not being implemented. In addition, the Facility reported that three medication variances regarding the wrong person had occurred (two in November and one in December 2013), indicating that the process was not being consistently implemented. ▪ 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 continued to indicate that most of the Medication Administration Observations conducted since the last review had resulted in passing scores. However given that the Facility's data showed that there were still a significant number of unreconciled excess/shortages of medications, the high passing rate regarding the Medication Administration Observations was highly suspect. However, 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 MAR blanks): ▪ June 2013 - 593 variances (296 returned medications and 297 MAR blanks); ▪ July 2013 - 514 variances (292 returned medications and 218 MAR blanks); ▪ August 2013 – 367 variances (80 returned medications and 287 MAR blanks); ▪ September 2013 – 634 variances (400 returned medications and 210 MAR blanks); ▪ October 2013 - 862 variances (522 returned medications and 262 MAR blanks); and ▪ November 2013 – 810 variances (513 returned medications and 243 MAR blanks). Based on observations of medication administration at Quail, the following problematic	

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		issues were found. Specifically, the nurse did not: ▪ Follow proper procedures by allowing the medications to flow into G-tubes by gravity. The nurse use the syringe to "push" the medications into the G-/tube; ▪ Check the correct position of the chain on the bed indicating the correct position as noted in the individual's PNMP; ▪ Know where to appropriately assess lung sounds when an individual demonstrated congestion and began to cough during administration of medications; ▪ Consistently tell the individuals what medication they were receiving; and ▪ Consistently provide instructions for positioning after medication administration to the direct support professionals. Since the last review, the Facility clearly had continued to take additional 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, such as 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 updated policies, and 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 (P&T) Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including whether calendar based on fiscal year or calendar year; o For Quarterly Drug Regimen Reviews (QDRR), 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 QDRR, two most recent per residence 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 including those for: Individual #309, Individual #33, Individual #140, Individual #88, Individual #114, Individual #130, Individual #124, Individual #98, Individual #55, Individual #259, Individual #65, Individual #239, Individual #25, Individual #115, Individual #7, Individual #126, Individual #45, Individual #174, Individual #233, Individual #86, Individual #299, Individual #156, Individual #290, Individual #70, Individual #76, Individual #205, Individual #258, Individual #304, Individual #191, and Individual #324; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders, including those for Individual #80, Individual #264, Individual #4, Individual #65, Individual #33, Individual #174, Individual #156, Individual #259, Individual #51, and Individual #6. For eight most recent QDRRs in which

	recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #184, Individual #267, Individual #83, Individual #255, Individual #25, Individual #276, Individual #264, and Individual #320; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; o Since the Monitoring Team's 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 (ADR) reports completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors/ variances per month for prior 12 months by error type, nurse, residence, shift, unit, individual, category of severity, 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 (i.e., 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 building; o Medication history for individuals with J or G/J-tubes (not G-tubes); o A schedule of when QDDRs are conducted by residence/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #288 (9/2/13, 1959hr), Individual #4 (10/3/13, 0842hr), Individual #4 (10/5/13, 1308hr), Individual #288 (10/1/13, 1123hr), Individual #288 (10/1/13, 1049hr), Individual #288 (10/3/13, 1528hr), Individual #288 (11/8/13, 1228hr), Individual #288 (11/8/13, 1251hr), Individual #288 (5/30/13, 1238hr), Individual #288 (5/30/13, 1202hr), Individual #288 (5/6/13, 1713hr), Individual #288 (6/25/13, 2139hr), Individual #288 (6/25/13, 2059hr), Individual #320 (6/18/13, 1934hr), Individual #288 (6/22/13, 1116hr), Individual # 320 (6/20/13, 0851hr), Individual #320 (6/11/13, 1645hr), Individual #320 (7/31/13, 1819hr), Individual #165 (7/31/13, 1330hr), Individual #288 (8/22/13, 2020hr), Individual #165 (8/14/13, 1052hr), Individual #165 (8/12/13, 1417hr), Individual #165 (8/2/13, 1029hr), Individual #165 (8/2/13, 0827hr), Individual #165 (8/1/13, 0812hr), and Individual #165 (8/1/13, 0950hr);

	○ Any trend analysis of chemical restraint use (graphs, etc.); ○ 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; ○ 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; ○ 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. When the data was collected periodically rather than continuously, the frequency of data collection was requested; ○ Presentation Book for Section N; ○ Medication Refusal policy 7/2/13(R); and ○ Pharmacy document: Analysis of returned medications. ▪ **Interviews with**: ○ Billy Bob Beck, RPh, Director of Pharmacy; ○ John Todd, RPh, Clinical Pharmacist; and ○ Anita Blackburn, CRPht, Technician.
	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: audits for new order processing, audits of QDRR content, audits of chemical restraint form completion, and audits of timeliness of chemical restraint form by pharmacy. ○ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. ○ The monitoring tools included adequate methodologies, such as review of contents of specific documents such as the QDRR and chemical restraint form. ○ 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: Clinical Pharmacist, and Staff Pharmacist. ○ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools for Sections N.1 to N.3. ▪ 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. Databases/data sources appeared comprehensive. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in substantial compliance with the following sub-sections: Sections N.1, N.2, N.3, N.4, N.5, N.6, and N.7. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas 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 further monitoring of medication variances within the Pharmacy Department. The Pharmacy Department continued to complete monthly QDRR Quality monitoring audits for Section N.3. A random sample of 10 completed QDRRs was reviewed from a designated residence each month. It appeared that each month, QDRRs from five residences were reviewed. Measurable indicators included the following: ▪ Each drug ordered for psychiatric use has an indication on the QDRR; ▪ Resident takes an atypical antipsychotic agent; ▪ Laboratory monitoring for the atypical agent is present and being monitored; ▪ Resident takes a drug for which serum levels are routinely monitored; ▪ Drug serum levels monitored? ▪ Resident takes a benzodiazepine; ▪ Benzodiazepine monitoring is done (clinical justification and side effects); ▪ Polypharmacy and clinical justification for use; ▪ Anticholinergics (side effects and clinical justification); and ▪ Low/high lab results noted on QDRR, if applicable. The auditor was to use specific evidence listed for each of the measurable indicators in determining compliance. Each measurable indicator was answered by a yes/no/not applicable decision, followed by percentage of compliance for that measurable indicator, if applicable. Some measurable indicators did not have a compliance score, because they were not applicable for scoring. The Pharmacy Department also had a monitoring tool to track the number of business days it took to complete the chemical restraint review. All chemical restraints were monitored using this audit tool. The monitoring tool included the following information: ▪ Date of restraint; ▪ Date of pharmacy review; ▪ The number of business days to complete the pharmacy review; ▪ Whether more than 10 business days occurred before completion of the pharmacy review; ▪ The psychiatry review date; ▪ The number of working days for psychiatry to review the chemical restraint document; and ▪ Whether more than 10 business days occurred before completion of the psychiatry review.

	Data was provided for each month of monitoring completed. If not already implemented, it is recommended that the QA nurse review a smaller sample size of chemical restraint documentation. Given there were errors in documentation of the actual medication (as discussed with regard to Section N.3), dosage, and route given for two individuals, including a review of this information in the audit tool would allow tracking and development of a process to ensure accuracy of entries. The Pharmacy Department utilized a separate monitoring tool in determining the quality/completeness of the pharmacy review/assessment of each chemical restraint. It was entitled "Chemical Restraint Pharmacy Monitoring: Pharmacist Reviews." The following measurable indicators were reviewed for each chemical restraint: ▪ Was the medication used in a clinically justified manner? ▪ Was the restraint effective? ▪ Was the order screened for drug-drug interactions with current regimen? ▪ Were there side effects or any adverse drug reaction? Each review was given a compliance score based on responses to these measurable indicators. The QA nurse also completed a smaller sample on a monthly basis. Inter-rater reliability was calculated and tracked. The Pharmacy Department met monthly with the QA nurse to review audit results. It is recommended that the actual month of the data discussed be included in the results (e.g., 5/28/13 minutes in which data results were discussed, but the month did not appear to be recorded). Meetings with minutes occurred on 5/28/13, 6/26/13, 7/23/13, 9/30/13, 10/23/13, and 11/21/13. Inter-rater reliability for the most recent month of data (October 2013) indicated 100 percent agreement with audits for Section N.3.
	Summary of Monitor's Assessment: For Section N, the Pharmacy Department had already demonstrated substantial compliance with Sections N.1, N.2, N.4, and N.7 for consecutive reviews. As a result, the parties agreed to suspend reviews of these sections for this review. The Pharmacy Department continued to complete the Quarterly Drug Regimen Reviews and the PCPs and the Psychiatry Department processed them in a timely manner. The chemical restraint forms were completed in a timely manner, and included quality information. The Pharmacy tracked the in-service training on Adverse Drug Reactions. Currently, all new hires received a basic course in health status change, which also applied to adverse drug reactions. Additionally, new nurses completed an ADR reporting course. The Pharmacy provided annual refresher training to the medical, pharmacy, and nursing staff. All of this training for ADRs appeared to be complete. Medication variances continued to be a challenge. The Pharmacy developed an additional internal audit process to track medication variances that occurred prior to dispensing the medication. Additionally, there were continuing efforts to assist nursing staff to reduce the numbers of excess unknown returned medications. This continued to be an area of challenge.

	In addition to the subsections already in substantial compliance, the Monitoring Team found the Facility to be compliant with Sections N.3, N.5, and N.6. The Facility remained in noncompliance with Section N.8.

#	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 parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency)	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u>	Substantial Compliance

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	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.	The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 26 chemical restraints used from 5/6/13 to 11/8/13. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that four individuals had 26 chemical restraints from 5/6/13 through 11/8/13. One individual had 13 chemical restraints. One individual had seven chemical restraints. One individual had four chemical restraints, and one individual had two chemical restraints. For the 26 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 26 chemical restraint forms, 26 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in 26 out of the 26 (100%) chemical restraint forms completed. ▪ Side effect, significant adverse effects, and drug-drug interactions were noted in 26 (100%) of the completed chemical restraint forms. ▪ There were seven statements that were considered recommendations. ▪ The range of time for completion of the forms from the date of the chemical restraint was from one to 19 days. It was noted that three were over the goal of the completion of the pharmacy review within 10 working days of the chemical restraint. One occurred in July 2013, and two occurred in August 2013. As noted in subsequent paragraphs, the Pharmacy met with the Psychiatry and Psychology departments and developed a system so that this would not recur. Based on submitted chemical restraint information from September through November, this appeared to have been corrected, because there were no pharmacy reviews exceeding 10 days after the chemical restraint administration. At the 10/11/13 P&T Committee meeting, the Pharmacy Department discussed results of the monitoring tool for chemical restraint review by pharmacists. Compliance was considered review in ten or fewer working days, as well as answering established questions during the review. According to the Facility's data, for June 2013, compliance was 100 percent for Pharmacy in six of six reviews for both timeliness and content of the review. For July 2013, compliance was 50 percent for two chemical restraints reviewed, because the Pharmacist reviewed one restraint 14 days after occurrence. There was 100 percent compliance with responding to established questions during the reviews. For August 2013, there were seven chemical restraints. Compliance with timeliness by Pharmacy was 57 percent as four of seven complaints were completed in 10 or less working days. Compliance was 100 percent for answering established questions for	

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		seven of seven reviews. Given the ongoing delays in the review process, a meeting was to be held with Psychiatry, Behavioral Health Services, and Pharmacy to determine options when the Behavioral Health Services staff responsible for the review process was unavailable. A copy of the nine-step process (undated) was submitted, entitled "Tracking of Behavioral Chemical Restraints by Psychiatry and Pharmacy." At the 1/9/14 P&T Committee, the Pharmacy continued to monitor timeliness and content of the pharmacy review of chemical restraints. According to the Facility's data, in September 2013, compliance was 100 percent for completing the reviews within 10 working days for one of one chemical restraint. In October 2013, compliance was 100 percent for completing the reviews within 10 working days for five of five chemical restraints. In November 2013, compliance was 100 percent for completing the reviews within 10 working days for two of two chemical restraints. Additionally, from the "chemical restraint pharmacy monitoring of pharmacist reviews" audit tool, compliance was 100 percent for content of the Pharmacy review. 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 documents showed the following: ▪ Of the 26 completed, there were 26 (100%) forms on which the psychiatry comment section was completed. ▪ For 26 of 26 (100%), clinical justification was documented. ▪ Side effects/drug-drug interactions were mentioned in 26 of 26 reviews (100%). ▪ Effectiveness was documented in seven of 26 (27%) of the chemical restraint form reviews. In determining improvement in compliance with this area, the more recent chemical restraints were reviewed to determine improvement in this area from the chronologically older documents. Documentation of effectiveness in the more recent months was as follows: Zero of one restraint in September 2013, four of five in October 2013, and one of two in November 2013. This was a total of five of eight (63%) chemical restraints. Given that the IDTs met after the chemical restraint event, a determination of effectiveness by both Pharmacy and Psychiatry departments provides guidance to the IDT in future use of the chemical restraint. It also provides evidence the Psychiatrist not only reviewed the events leading up to the justification of the chemical restraint, but also provides evidence of Psychiatry review of the effects and effectiveness of the medication used. When effectiveness was documented in a more detailed, alternate format (i.e., psychiatry IPN), reference to this document was not entered on the chemical restraint form. A simple checkbox	

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		system (either indicating effectiveness or not, or referring the reader to a psychiatry IPN) added to the psychiatry section of the chemical restraint form would prevent potential illegibility issues and ensure this area was completed on the chemical restraint form. ▪ Psychiatry provided evidence of alternate documentation of effectiveness of the chemical restraint, follow-up evaluation, and plan for one individual as an example of documentation, which addressed effectiveness. The example provided was for one individual receiving multiple chemical restraints. The Incident Management Review Team Meeting documentation related to the chemical restraint also was provided. However, of significance to the issue of Psychiatry determining effectiveness of the chemical restraint, there were copies of separate, typed psychiatry IPNs written by psychiatry in SOAP format. These notes included a review of the event, the medication given, and the current status/effectiveness, with a home visit by the Psychiatrist in several instances to determine current status, as well as side effects observed. One of the positive steps was that the IDT invited the Psychiatrist to an IDT meeting to discuss the chemical restraint. For those individuals administered multiple or serial chemical restraints, this would provide the IDT with additional immediate guidance not provided in other documentation. It appeared psychiatry might have been documenting their evaluation of the chemical restraint use, as well as the outcome of the chemical restraint use, and the Psychiatrist's plan in the IPN, which was a separate document from the chemical restraint form submitted to the Monitoring Team member. This note appeared to adequately communicate to the IDT the effectiveness of the chemical restraint as determined by the psychiatrist. ▪ There were 12 recommendations documented. ▪ Three of 26 chemical restraints were reviewed over the 10-day goal. These all occurred in August 2013. It appeared the system implemented since that time allowed for timely review of the documents. ▪ Separately, it was noted that two medication doses and routes had errors in documentation by the staff administering the medication at the time, or the physician order was written in error. However, neither the Pharmacy nor Psychiatry Departments corrected these errors in the documentation their departments completed. For one, an order was written for Zyprexa, but Ativan was given. It was not determined if this was also captured as a medication variance. ▪ The chemical restraint form included numerous pages, yet not all pages included the individual's name, or the forms were handwritten (which was difficult to understand at times). Ensuring the individual's name is stamped on each page of the document would be beneficial.	

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		In summary, in October 2013, the Facility began implementation of a nine-step process to improve the timeliness and content of the reviews of chemical restraints. Based on review of the chemical restraint documentation since then, improvements were seen. In addition, the Facility provided sample documentation showing that Psychiatric IPNs included information related to effectiveness. This note appeared to adequately communicate to the IDT the effectiveness of the chemical restraint as determined by the psychiatrist. At times, IDTs had met with the Psychiatrist to obtain more information and discuss options. It would be helpful when effectiveness was documented in a more detailed, alternate format (i.e., psychiatry IPN), for a reference to this document to be entered on the chemical restraint form. However, the Facility now had a system for the Pharmacy as well as Psychiatry Departments to review and comment on chemical restraints, including effectiveness. As a result, the Facility was considered to be substantially compliant with these requirements. Continued findings of substantial compliance will be based on full implementation of these processes going forward. <u>Polypharmacy</u> Of the 30 QDRRs reviewed, polypharmacy was noted in 21 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 21 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 21 of 21 (100%). References to meeting minutes, specialty consultations, etc., were included where applicable in documenting the clinical need for polypharmacy. ▪ Potential interactions with other drugs or food/side effect risk were reviewed in 21 of 21 (100%). ▪ For 21 of 21 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. The P&T Committee meeting of 10/11/13 included a psychotherapeutic polypharmacy update by psychiatry. For the prior quarter, 126 individuals received psychoactive medication. The number of individuals in the active polypharmacy category, new admission category, or stable polypharmacy had remained stable. The P&T Committee meeting of 1/9/14 included a psychotherapeutic polypharmacy update by Psychiatry. For the prior quarter (September through November 2013) 123 individuals received psychoactive medication. The number of individuals in the active polypharmacy category varied from 12 to 15, the number in the new admission category with polypharmacy ranged from three to four, and the number of individuals with stable polypharmacy was 15. There were no trends noted. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 12 of the 30 QDRRs.	

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		▪ Of these, 12 of 12 (100%) documented justification with appropriate diagnoses; and ▪ Twelve of 12 (100%) QDRRs indicated whether side effects or other significant risks were present. <u>Anticholinergic Monitoring</u> Of the 30 QDRRs, 30 (100%) were screened for medications associated with potential significant anticholinergic side effects. Fifteen QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 15 of 15 (100%) of cases with this medication prescribed; ▪ Fifteen of 15 (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. ▪ Fifteen of 15 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 30 QDRRs reviewed, 12 listed atypical antipsychotic medication. Of these, 12 (100%) included lab values that reviewed endocrine and metabolic risks [i.e., Basic Metabolic Panel (BMP), glucose level, Hgb A1C, and/or lipid panel, as appropriate]. Based on the Monitoring Team's findings, the Facility was found to be in substantial compliance with Section N.3.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
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	As discussed with regard to Section J.12, the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months (per the Healthcare Guidelines). An important component of this review was also the latency	Substantial Compliance

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	dyskinesia.	between the time that the Nurse or Psychiatry Assistant completed the evaluation 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 evaluations. As noted above, since the last review, the Psychiatry Assistant had retired from this position. The Psychiatric Nurse was currently performing the DISCUS evaluations. This staff member had received training on how to utilize the DISCUS several years ago, and more recently, had gone through the training provided to the nurses at LBSSLC. In the interim, between the retirement of the Psychiatry Assistant and the beginning of the Psychiatric Nurses' employment, the two Psychiatrists performed the DISCUS on the individuals they followed in conjunction with the Quarterly Psychiatric Reviews. The staff Psychiatrist had continued to perform the DISCUS evaluations on the individuals he followed, and the Director of Psychiatry shared the responsibility with the Psychiatric Nurse. The review of the sample of the records of 19 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months), and had been performed at least every six months for all 19 (100%) individuals. The review of these documents during the current and prior Monitoring Team reviews indicated that the Facility performed the MOSES on all individuals for whom they were required in the months of January and July. This policy had been implemented to increase the completion rates of those evaluations, and appeared to have been successful. 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 19 (100%) 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 were also 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 had performed the DISCUS for those individuals prescribed Reglan, and the Nurse Case Manager performed the MOSES evaluations. Based on the review of the most recent DISCUS evaluations for these individuals, the Psychiatric Nurse	

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		was now performing them. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of five of the 21 (24%) individuals fitting the above criteria was selected: Individual #323, Individual #136, Individual #199, Individual #225, and Individual #62. Review of the records of these individuals indicated that the MOSES evaluations had been performed as required for all (100%) five individuals. However, the second page of the July 2013 evaluation documentation was not completed and, thus, no prescriber signature could be located for any of the following five individuals: Individual #323 (7/8/13), Individual #136 (7/9/13), Individual #199 (7/10/13), Individual #225 (7/3/13), and Individual #62 (7/8/13). The same sample was utilized to assess the completion of the DISCUS for individuals receiving Reglan. The results of this review indicated that these evaluations were completed as specified for all five (100%) individuals. The prescribing physician had also reviewed and signed these evaluations in a timely manner for four (80%) of the five individuals in the sample. The 11/16/13 DISCUS for Individual #199 was not reviewed and signed by the prescriber until 12/18/13. The review of the completion rates of both the MOSES and the DISCUS from the overall sample of 19 of the 123 (15%) individuals prescribed psychotropic medication indicated that these evaluations had been completed and reviewed by the prescriber, as specified for all (100%) of the individuals. These uniformly high rates of completion indicated the Facility had developed a system to routinely ensure side effect monitoring tools were completed, as specified in the Settlement Agreement. These results were consistent with those contained in the spreadsheet the Psychiatry Department maintained to track their own performance. The results of the Monitoring Team's current review indicated that those evaluations were also being performed as required for those individuals prescribed Reglan. However, there was a failure of the system related to the timely review of the sample of five individuals' MOSES evaluations performed in July 2013, because the prescriber had not signed the second pages of these documents. The finding of substantial compliance was continued due to the completion rate of the performance and review of these evaluations for the general population of 123 individuals at LBSSLC prescribed psychotropic medication. However, the Facility should investigate the circumstance surrounding the deficits related to the review of the July 2013 MOSES for the sample of five individuals prescribed Reglan, as noted above.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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<tr><td>N6</td><td>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.</td><td>The policy: “LbSSLC – Health Services: Adverse Drug Reaction Reporting” remained in place, and was dated 7/22/11.

<u>New Hires</u>
The 10/11/13 P&T Committee meeting documented that each newly hired direct support professional, nurse, and other healthcare professional completed the clinical observations course during orientation. Newly hired nurses also completed the “Adverse Drug Reaction Recognition and Reporting” course. Additionally, reminders were posted in the residences providing instruction of when and whom to call for changes in status, which would include adverse drug reactions.

The Facility continued to train new employees on the curriculum for “Observing and Reporting Clinical Indicators of Health Status.” This curriculum included information concerning drug reaction signs and symptoms. The submitted information included training rosters entitled: “Active Employee Course Participation Report.” Two reports were submitted. One report was dated 8/1/11 through 11/15/13, and included those new employees from all departments that completed the course: “Observing and Reporting Clinical Indicators of Health Status.” This listed 597 employees as completing the course. A more recent report, dated 5/1/13 through 10/31/13, indicated 103 new employees had been trained. This included all departments (i.e., residential, nursing, etc.).

Nurses completed a “Nursing Orientation” training as new employees, in addition to the new employee orientation. Included in the “Health Services In-Service Outline” was the topic “Adverse Drug Reaction Recognition and Reporting.” The following chart indicates the date of training and number of nurses trained for the year prior to the Monitoring Team’s visit:

<table>
<tr><th>Date</th><th>Number of Nurses Trained</th><th>Date</th><th>Number of Nurses Trained</th></tr>
<tr><td>12/21/12</td><td>1</td><td>7/19/13</td><td>3</td></tr>
<tr><td>2/22/13</td><td>2</td><td>8/29/13</td><td>2</td></tr>
<tr><td>3/25/13</td><td>2</td><td>9/11/13</td><td>3</td></tr>
<tr><td>4/3/13</td><td>2</td><td>9/13/13</td><td>2</td></tr>
<tr><td>4/22/13</td><td>2</td><td>9/20/13</td><td>1</td></tr>
<tr><td>5/8/13</td><td>1</td><td>11/5/13</td><td>3</td></tr>
<tr><td>5/20/13</td><td>8</td><td>11/18/13</td><td>1</td></tr>
<tr><td>6/21/13</td><td>3</td><td></td><td></td></tr>
<tr><td>6/27/13</td><td>3</td><td>Total</td><td>39</td></tr>
</table>
</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Pharmacy and Medical Staff Information was submitted spanning the entire 12 months. For the earlier six-month time period through July 2013, the following information was submitted as evidence of annual refresher training: ▪ For medical, psychiatry, and pharmacy staff, the following training was completed: o Four PCPs and two Psychiatrists completed a refresher course in ADRs, on 5/14/13, at an in-service entitled "PCP Training – Adverse Drug Reaction Reporting." The Clinical Pharmacist taught this course. o Five Pharmacy staff completed a refresher course in ADRs, on 5/14/13, at an in-service entitled "Pharmacy Training – Adverse Drug Reaction Reporting." The Clinical Pharmacist taught this course. o One Pharmacist and one Psychiatrist, who had also attended the 5/14/13 in-service, signed a roster of attendance for 5/9/13 for "Adverse Drug Reaction Reporting." The reason for the redundancy was not documented. Nursing Department – Refresher Training From a submitted roster entitled: "LBSSLC Roster as of 6/25/13," 82 nurses were listed in highlight, which was interpreted as completing the training. An additional six were not highlighted and indicated the need to complete training. Three others were out on leave. Seven others were listed as having discontinued employment. Trained versus total nurses to be trained was 82 of 88 (93%). This was similar to the above Pharmacy report. From a submitted document entitled: "Summary of Adverse Drug Reaction Refresher Training June-July 2013," the data as of 7/3/13 was summarized for training of nurses in the refresher course on ADRs. As of 7/3/13, there were 89 nurses on the payroll. Three nurses were on FMLA and one was in the process of completing a new employee orientation. There remained 85 nurses for whom annual in-service training (either through a refresher course or as a new hire orientation training during the year) was expected. As of 7/3/13, 80 of 85 (94%) had completed this training. An updated roster was provided as of November 15, 2013. This listed 85 nurses. Two nurses were on FMLA. Of the 83 remaining nurses, all 83 (100%) had completed a refresher course on Adverse Drug Reactions. The following table summarizes the in-service provided to the Nursing Department for the refresher course: "Adverse Drug Reaction Recognition and Reporting," dated June 24 to 28, 2013, with the Clinical Pharmacist as the instructor:	

#	Provision	Assessment of Status	Compliance

Roster Signature Date of Training	Number of Nurses Trained	Roster Signature Date of Training	Number of Nurses Trained
6/24/13	17	6/29/13	3
6/25/13	31	7/1/13	3
6/26/13	8	7/2/13	2
6/27/13	13	7/3/13	2
6/28/13	16		
Undated	1	**Total**	**96**

This number exceeded the 79 completing refresher training from the document the Pharmacy Department submitted. It was observed that some nurses had signed more than one roster and were double counted in the above table.

The following table represents data extracted from the ADR reports submitted:

Date	Medication	Reaction	Date Notified Pharmacy	Naranjo ADR Problem Scale	ADR by Evidence	Added to Allergy Profile/Drug Alert
June to August 2013	No ADRs reported	NA	NA	NA	NA	NA
September to November 2013	No ADRs reported	NA	NA	NA	NA	NA

The minutes of the 10/11/13 P&T Committee meeting indicated the number of ADRs reported in the prior quarter was zero. Because of the details documented in the clinic review list, which was presented at each provider morning meeting, as well as the discussion of acute care cases, it would be expected that one or more participants from several departments represented would have identified a potential adverse drug reaction had any occurred. The provider morning meeting was an additional mechanism to identify ADRs should they occur, in additional to the clinical IDT members in the residential setting.

The discussion at the 1/9/13 P&T Committee meeting indicated there were no reported adverse drug events in the prior quarter.

Based on the training provided to staff, and the systems in place to identify ADRs, the

#	Provision	Assessment of Status	Compliance
		Facility remained in compliance with this provision.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	<u>Policies and Procedures regarding Medication Variances</u> There were no new policies concerning medication administration. There were no new policies concerning medication errors/variances. There was a new or revised policy entitled: "LbSSLC – Review Processes: Pharmacy and Therapeutics Committee," dated 11/6/13. <u>Pharmacy Review of Categorization of Errors</u> Additionally, the Pharmacy Department was active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. From the 1/7/14 Medication Safety and Systems Committee. Pharmacy had reviewed a sample of 40 (7.5%) variance reports from October 2013, and there was 100 percent agreement with the categorization for level C errors. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Safety and Systems Committee meetings, which the Clinical Pharmacist chaired. Since the Monitoring Team's last visit, the Committee met on August 21, 2013, September 27, 2013, October 23, 2013, November 20, 2013, and January 7, 2014. The following table describes some of the findings of this committee. The number of medication variances per department were provided per month:	Noncompliance

#	Provision	Assessment of Status	Compliance

Month	Pharmacy Department	Nursing Department	Medical Department	Dental Department
June 2013	0	593	0	Not Stated (NS)
July 2013	3	510	1	NS
August 2013	0	367	0	NS
September 2013	22	263 (revised 612)	0	NS
October 2013	71 (revised 72)	227 (revised 790)	0	NS
November 2013	49	761	0	NS

The number of medication variances per month were categorized:

Month	Category A	Category B	Category C	Category D	Category E
May 2013	146	0	200	0	0
June 2013	297	0	296	0	0
July 2013	218	0	296	0	0
August 2013	287	0	80	0	0
September 2013	216 (revised 229)	3	66 (revised 402)	0	0
October 2013	288 (revised 333)	1	10 (revised 528)	0	0
November 2013	291	1	517	0	0

A description of major categories of medication variances per month included the following:

Month	Excess Unknown Returns (Doses)/Units*	Unknown Shortage (Doses)	MAR Not Initialed	Documented Omission
May 2013	200/808	0	146	0

#	Provision	Assessment of Status	Compliance

June 2013	296/1266	0	297	0
July 2013	292/1289	0	218	0
August 2013	80/284	0	287	0
September 2013	66/252 (revised 400/571	0	197 (revised 210)	0
October 2013	8/37 (revised 522/766	0	217 (revised 262)	0
November 2013	513/749	0	243	0

*Although the data was converted in August 2013, there appeared to be two continuing sets of data. One data set was entitled: "Medication Variance by Type," and listed "med not given – unexplained ret med," and the second data set/chart was entitled: "Unexplained Returned doses of medication – fiscal year 2014." This had previously been entitled: "Unexplained returned units of medication – fiscal year 2013." As the two numbers remained different, it appeared that the unit number was being maintained, and this was reflected in the continued entry in the above table. This will need further clarification at the Monitoring Team's next visit.

Information from the 8/21/13 Medication Safety and Systems Committee (including a review of the draft minutes from 7/9/13) indicated that a program of identification (ID) card implementation for each individual had been initiated and was ongoing. Nursing continued to check the medication rooms monthly for expired medications and other expired health care items. Medication counts were ongoing in six residences, as one program to reduce unexplained medication returns (medications were to be counted at shift change each day). Nursing was completing MAR observations weekly, and variance reports were created when blanks were identified in the MAR. Additionally, Pharmacy conducted spot checks on each of the 15 homes. A 20 percent sample of the residential population was reviewed at each audit, with a review of MAR charting and the medication count at that point in time in the medication rooms. According to the Facility's data, for June 2013, zero of 15 residences were compliant. For July 2013, there were three of 15 residences with 100 percent compliance. Results were forwarded to the Nurse Manager for corrective follow-up action, and copies of the actions were returned to the Pharmacy and Medical Director.

The 9/27/13 Medication Safety and Systems Committee draft minutes indicated the Pharmacy spot checks showed that two of 15 residences were 100 percent compliant. The Nursing Medication Room Reviews report for August 2013 indicated 11 of 15 residences were 100 percent compliant with the August audit. A new report entitled: "LBSSLC Returned Medication for Seizure Report," for August 2013, was reviewed in

#	Provision	Assessment of Status	Compliance
		which seizure activity was researched for correlation with unexplained returned seizure medications. The report was to be provided monthly. The 10/23/13 Medication Safety and Systems Committee draft minutes indicated the Pharmacy reviewed unexplained returned medications and determined that 26 percent were laxatives, 17 percent were psychoactive medication, and 12 percent were anti-epileptic medications. The Pharmacy spot check monitoring showed that two of 15 residences were 100 percent compliant. The Nursing Medication Room Reviews indicated that nine of 15 homes were 100 percent compliant for September 2013. The Unexplained Returned Seizure Medication Report did not indicate any correlation of events with unexplained returned medication prior to the event. The 11/20/13 Medication Safety and Systems Committee draft minutes indicated that counting of medication per shift change on the six pilot residences was suspended, because the nurses were not actually counting medications. There remained a discrepancy between the number of medications documented on the MARs and the number returned to the Pharmacy. On December 1, 2013, a new medication variance process was to be initiated. Medications were to be delivered in 24-hour increments to the 2 p.m. to 10 p.m. shift nurses in the residence, and the 6 a.m. to 2 p.m. shift nurses were to return any medications remaining at the end of the 24-hour period, also completing variance reports on the medications at that time. Two residences were assigned to this pilot project. The Pharmacy spot check audits of the medication rooms indicated zero of 13 had 100 percent compliance, and two residences were not done due to restricted access to those homes. A report was presented for the residential services monitoring of the medication pass activity through August 2013. The overall campus compliance was 92 percent. The Nursing Medication Room Reviews documented that six of 14 residences were 100 percent compliant. One residence was not reviewed. The 1/7/14 Medication Safety and Systems Committee draft minutes included a summary of data from the Pharmacy spot checks of the medication room audits. Based on the Facility's data, it was found that 41 percent of the reviews were 100 percent compliant. There did not appear to be a trend from May through October 2013. A reduced schedule of spot checks was provided for the 2014 calendar year. Each month, specific residences were to be included in the spot check. These averaged five residences per month and all residences were to be audited within each quarter. A report was submitted entitled: "Review of Medication Variance Severity Scoring." The Pharmacy Department reviewed a sample of category C errors, as determined by the Nursing Department. A sample size of 40 (7.5% of all variances) was reviewed. There were no differences in the Pharmacy categorization versus the Nursing Department categorization. Of concern, there was no review of the large number of Category A	

#	Provision	Assessment of Status	Compliance
		medication variances to determine if the Nursing Department was inadvertently reducing the severity of Category C or B medication variances. This would not be found when only Category C medication variances were reviewed. The Nursing Medication Room Reviews for November 2013 documented that eight of 14 had 100 percent compliance. One residence was not audited due to restricted access. The new process for medication variance, with delivering medications every 24 hours to the 2 p.m. to 10 p.m. shift, had been delayed and was started on January 6, 2014. The September and October data concerning medication variances was revised, due to challenges in the Avatar database entry system and accessing information. The tables above include the revised data. The P&T Committee also provided oversight for medication variances. A meeting was held during the Monitoring Team's last visit, on 7/10/13. The committee continued to meet quarterly, on October 11, 2013, and during the Monitoring Team's most recent visit, on 1/9/14. The draft minutes of the 10/11/13 Pharmacy and Therapeutics Committee indicated that there had been 10,379 unexplained units of medication returned for the first 11 months of the fiscal year, and a total of 284 unexplained doses for the month of August. As other SSLCs had been reporting in doses rather than units, medication variances were to be reported in doses at LBSSLC in future reports. The discussion at the 1/9/14 P&T Committee included several handouts concerning medication variance updates and current data. These have already been reviewed in the tables listed above and the review of minutes of the Medication Safety and Systems Committee. <u>Additional Pharmacy monitoring processes</u> To further reduce the number of medication variances, the Pharmacy Department designed and implemented systems, collaborating with the Nursing Department as needed. The Pharmacy Department provided updated information concerning revised internal surveillance of medication variances within the Pharmacy Department. Two amended/new forms were developed to track medication variances originating from the Pharmacy Department. This included details of the severity category, and identification of which were a pharmacy error discovered prior to dispensing, and which were dispensed and discovered by nursing. This information was available starting in September 2013. The following chart includes information derived from these reports:	

#	Provision	Assessment of Status	Compliance

Month	Severity Category	Pharmacy - Not dispensed	Dispensed – Nursing Reported	**Total**
September 2013	A	19	0	**19**
September 2013	B	0	3	**3**
September 2013	C	0	0	**0**
October 2013	A	71	0	**71**
October 2013	B	0	1	**1**
October 2013	C	0	0	**0**
November 2013	A	48	0	**48**
November 2013	B	1	0	**1**
November 2013	C	0	0	**0**
Total		**139**	**4**	

Each month, Pharmacy staff completed a "Pharmacy Medication/MAR Audit" on each residence. The sample size was at least 20 percent of the MARs/medication reviews. The documents reviewed during the audit included the pharmacy fill list, the signed fill list return sheet, a copy of the MAR, and a copy of the excess medication forms. A template was used, which included the date of the audit, the closure concern, the responsible department or person, the action steps needed, guidance concerning preventive measures, date of resolution of closure concerns, and a summary of residence compliance percentage.

This information was also reflected in a form entitled: "Medication Variances by Type," which was completed monthly. This form included several categories of medication variance, including prescribing, transcribing, dispensing, administering, and monitoring. Under the dispensing category, two new dispensing categories were added, to reflect increased precision of information: "internal variance – cart fill," and "incorrect quantity of meds sent."

This submitted information provided evidence of increased monitoring of medication variances, which would potentially originate from the Pharmacy Department. This provided an increased level of accountability and tracking/monitoring to improve and maintain compliance.

<u>Medication Room and Cart Inspections by Nursing Department</u>
The "QA/QI Quarterly Section Review N of 10/15/13" documented that the data from the Nursing Medication Room reports was reviewed at the Medication Safety and Systems Committee. Minutes recording this information were discussed earlier in this section.

#	Provision	Assessment of Status	Compliance
		Medication Error/Variance Reports Copies of the last 10 medication error forms were requested for review. The review indicated one had been duplicated, resulting in forms for nine medication errors being submitted. The Monitoring Team member reviewed and classified the medication variances according to the State Office policy/guideline. Nursing indicated there were zero Category A medication variances, eight Category B medication variances, zero Category C medication variances, and one Category D medication variance. The Monitoring Team member's interpretation of the information provided indicated there were zero Category A medication variances, one Category B medication variances, seven Category C medication variances, and one Category D medication variance. Medication variances occurred with Oxazepam, Lorazepam, Haldol, Clonazepam, Cholecalciferol, Ibuprofen, and Calcium. Four medication variances occurred with Lorazepam. It was noted that the nursing staff categorized many Category C medication variances as Category B variances. The seven Category C medication variances were all considered Category B by the Nursing Department, yet the information provided indicated there was evidence of omission of medication traced to a specific medication pass and nurse. These variances were not considered unknown excess returns. However, given that the Pharmacy did not review Category A or B variances, the current Pharmacy monitoring process would not identify this concern. It is recommended that the Pharmacy expand review of the audit of categorization of severity to include Category B medication variances. For each case, the "Medication Variance Report" form was a two-page form, of which the first page was completed. The second page remained incomplete/unutilized. A separate print out of the medication variance also was attached, but did not provide additional information than the first page of the "Medication Variance Report" form. The form did not indicate follow-up action plans for the medication variance in eight of nine medication variances. One of nine submitted copies had follow-up information provided. It appeared the form was not utilized, and that nursing potentially had follow-up documentation through another set of forms. However, evidence of follow-up was only documented in one of nine (11%). Medication Observation Monitoring According to the Nursing Department, there were no reports available, which reflected medication administration observation summarization or data analysis. In summary, 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. A significant remaining concern was the large number of unexplained returned medications. Of serious concern are the potential clinical implications of	

#	Provision	Assessment of Status	Compliance
		individuals possibly not receiving prescribed medication, and it was positive that the Facility had begun to look at this for one diagnosis (i.e., seizure disorders). However, further work was needed 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. In addition, based on the Monitoring Team's review, problems existed with the Nursing Department's categorization of medication variance, particularly the miscategorization of Category C variances as Category B variances. The Pharmacy Department's current review methodology did not pick up on these errors, but should be revised to do so.	

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 #165, Individual #190, Individual #269, Individual #233, Individual #135, Individual #114, Individual #167, Individual #62, Individual #324, Individual #53, Individual #73, Individual #235, Individual #51, Individual #14, and Individual #132) and an additional three individuals who received direct OT/PT therapy (i.e., Individual #87, Individual #99, and Individual #301): Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team members required 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, PNMT 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 eight individuals in Sample O.2 (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, Individual #308, and Individual #76) on the PNMT caseload who were assessed or reviewed in the last six months: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members required 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 six individuals in Sample O.3 (i.e., Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, and Individual #89): 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 PNMPs/Dining Plans for the following 41 individuals: Individual #285, Individual #367, Individual #35, Individual #67, Individual #282, Individual #200, Individual #159, Individual #45, Individual #198, Individual #304, Individual #136, Individual #326, Individual #202, Individual #65, Individual #327, Individual #141, Individual #356, Individual #194, Individual #179, Individual #209, Individual #301, Individual #359, Individual #87, Individual #153, Individual #200, Individual #251, Individual #348, Individual #138, Individual #16, Individual #93, Individual #212, Individual #307, Individual #207, Individual #368, Individual #287, Individual #99, Individual #313, Individual #145, Individual #158, Individual #106, and Individual #243; 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 in which PNMT members participated;

	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;

	○ List of completed PNMT Nursing Post Hospitalization Assessments/Evaluations; ○ Quality Assurance/Quality Improvement (QA/QI) meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; ○ Minutes from the HT Department meetings for the past six months; ○ External PNM consultant reports since the Monitoring Team's last review; ○ Changes to PNMP templates since the Monitoring Team's last review; ○ QA/QI Quarterly Section Review for Section 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); ○ Number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); ○ Number of current staff who have completed annual refresher training (n), over number of staff required to complete annual refresher training (N); ○ At-Risk Rating List; ○ License numbers of PNMT core members; ○ Copy of PNMT referral form; ○ List of approved trainers for NEO and annual refresher PNM foundational training; ○ List of approved trainers for PNM individual-specific training (i.e., non-foundational); ○ List of PNM monitors, and for each monitor listed, include date of NEO training competencies completed, and check-offs completed for validation and inter-rater agreement; ○ PNMT meeting minutes and attendance sheets completed after submission of pre-review document request; ○ NEO training curriculum for PNM foundational training; ○ QA/QI Indicators for Sections O, P, and R; ○ Information flyer for Z pillow and Tortoise positioner; ○ Assistant Director of Program's Mealtime packet; ○ Violet and Iris Plans of Correction for Mealtime monitoring results; ○ Training roster for Facility Pulled Staff policy; ○ Protocol for Pathway to Return to Oral Eating and Less Restrictive Intake; ○ PNMT meeting minutes from 11/15/13 to present; ○ Procedure for PNMP Revision; ○ Emails to expand sustainable system for PNMP implementation; ○ Nutrition Services Policy; ○ Nursing Policy for Weight Variance; and ○ Protocol: Nutrition Services Weight Monitoring; ▪ **Interviews with:** ○ Linda Thomas, Director of Habilitation Therapy; ○ Missy Olive, PNMT PTA; ○ Corey Verett, Chief Clinical Dietician, PNMT Dietician; ○ Megan Copeland, PNMT OT;

	o Robin Seale, Assistant Director of Programs (ADOP); o Rodshadi Moore, Active Treatment Coordinator; and o Norma Guterrez, Safety Officer. ▪ **Observations of:** o Individuals in multiple residences, dining rooms, and day programs, including Individual #285, Individual #367, Individual #35, Individual #67, Individual #282, Individual #200, Individual #159, Individual #45, Individual #198, Individual #304, Individual #136, Individual #326, Individual #202, Individual #65, Individual #327, Individual #141, Individual #356, Individual #194, Individual #179, Individual #209, Individual #301, Individual #359, Individual #87, Individual #153, Individual #200, Individual #251, Individual #348, Individual #138, Individual #16, Individual #93, Individual #212, Individual #307, Individual #207, Individual #368, Individual #287, Individual #99, Individual #313, Individual #145, Individual #158, Individual #106, and Individual #243; and o PNMT meeting, on 1/9/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 12/20/13. 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. Based on a review of the Facility Self-Assessment for Section O, as well as interviews with the Director of HT, the following was found: ▪ In September 2013, Facility staff began tracking identified key indicators. The Administrative Outcome Measure document presented data that had been collected for the months of September, October, and November 2013. The key indicators for Section O were: o Physical, Mental and Behavioral Health and Well-Being ▪ Number of hospitalizations per month; ▪ Number of emergency room visits per month; ▪ Number of residents diagnosed with aspiration pneumonia monthly/yearly; ▪ Number of residents diagnosed with all pneumonia monthly/yearly; ▪ Number of residents with choking incidents per month; ▪ Percentage of residents who eat enterally and receive annual evaluation for medical necessity of enteral eating, which includes an assessment for reasonable alternative treatment strategies; ▪ Number of residents returned to less restrictive form of eating; ▪ Number of PNMPs that contain instructions for mealtime techniques, positioning, oral care, and medication administration for residents with identified needs; ▪ Number of PNMT assessments completed within 30 days of referral; ▪ Percentage of residents who have an integrated OT/PT assessment that considers significant health issues and risk indicators; and ▪ Number of residents receiving enteral feeding; o Preventative Care and Disease Management

	▪ Number of residents at high risk for aspiration; o Access to Services ▪ Number of residents with an identified need for assistive equipment. The tracking and trending of QA/QI key indicators for Section O was a step in the right direction. However, many of these "indicators" were demographic in nature (e.g., numbers of individuals with feeding tubes, number of individual at high risk, etc.), and most did not address quality. Many of them also were not specific enough to provide information necessary for analysis (e.g., numbers of hospitalization per month, numbers of emergency room visits, without information related the reasons for these events). In addition, additional work will need to be completed in the development of methodologies, standards, and criterion to support reporting accuracy with these key indicators. ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-based audit tools for PNMPs, and PNMT assessments, and the Compliance Monitoring form. The Facility was not using the State Monitoring Tool for Section O. o The Self-Assessment identified the sample sizes used to complete audits. For a number of samples, the number in the sample (n) was identified in comparison with the total population size (N). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. . o The following staff/positions were responsible for completing the audit tool: The Director of HT and therapists. Currently, no Facility PCMs were responsible for completing the Self-Assessment. The Director of HT and therapists were working with a Facility PCM to provide training in compliance monitoring. In the future, if data is collected by a PCM, it should be identified in the Self-Assessment. ▪ The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as review of PNMT/IDT meeting attendance sign-in sheets, PNMT referral forms, daily reports from the PNMT RN, PNMT RN weekly report to medical providers, PNMT Episode Tracker, Mealtime data from Assistant Director of Programs, etc. ▪ The Facility used other relevant data sources, including, for example, Competency Training and Development participation rosters for new employees and veteran staff, QIDP database for assessment completion and attendance, review of Provision Action Information, HT monitoring database, Facility Integrated Risk Ratings – by Home, continuing education database, and review of Master Lists (e.g., individuals who receive enteral nutrition, individuals who require mealtime assistance, individuals who received a Modified Barium Swallow, PNMP database, etc.). ▪ The Facility presented some of the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with the following subsections: Section O.1 and O.5. This was consistent with the Monitoring Team's findings. The Facility rated itself as not being in compliance with Sections O.2, O.3, O.4, O.6, O.7 and O.8. The Monitoring Team found the Facility in substantial compliance with Section O.4. The Monitoring Team's findings showed noncompliance ratings for Section O.2, O.3, O.6, O.7 and O.8, which was consistent with the Facility's findings for these subsections.

	▪ The Facility's data identified some areas in need of improvement, but did not provide specific information regarding the analysis of the information and/or the development of interventions to address findings that did not support compliance.
	Summary of Monitor's Assessment: At the time of the Monitoring Team's review, the Facility had policies, protocols, and guidelines related to physical and nutritional supports that incorporated necessary elements; the PNMT had the required core members as outlined in the Settlement Agreement; PNMT members had exceeded the annual requirements for continuing education, and the continuing education completed was relevant to the physical and nutritional supports and was transferrable to the population served; the PNMT was consulting with medical providers and IDT members in a variety of ways; the PNMT was meeting on a regular basis; and the PNMT had established a system to resolve identified systems issues. The Facility was found to be in substantial compliance with Section O.1. The Facility had a sustainable system to maintain and update lists identifying each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration. On 10/1/13, a PNMT referral form was implemented, which had increased the number of individuals referred to the PNMT. However, some individuals in the Monitoring Team's sample should have been referred to the PNMT, but were not. The PNMT assessments and action plans included many of the necessary components. The Facility Self-Assessment indicated: "this provision is not in substantial compliance; ensuring ISPA is documented and filed and integration into the IHCP are not consistently completed." This was consistent with the Monitoring Team's findings that additional work needed to be done to integrate PNMT recommendations into IHCPs. The mealtime observations completed during this review were a significant improvement from the last review, at which time none of the mealtime observations showed that staff were adhering to individuals' dining plans. During this review, observations showed over 80 percent adherence to the dining plans, and prior to the review, the Facility had identified residences in which problems were occurring, and corrective action plans already were in place. The Facility is to be commended for their commitment in continuing to revise their Mealtime Coordination system to achieve the outcome of ensuring staff do not engage in unsafe mealtime practices and striving to support a mealtime environment that supports independence for individuals. The Facility was found to be in substantial compliance with Section O.4. The Facility had implemented a comprehensive PNM foundational training program for new employees and veteran staff. In September 2013, a mandatory PNM foundational annual refresher training had been initiated. The Facility therapists had identified 28 individuals who required PNMP individual-specific training. There was a sustainable system developed and implemented for the provision of individual-specific training for staff. The Facility was found to be in substantial compliance with Section O.5. The Facility had developed and implemented a PNM monitoring policy with operational guidelines, including the necessary components. However, PNMP monitoring was not occurring at the established frequency for individuals with high and/or medium PNM risks.

	The Facility had developed a protocol to define the system for effectiveness monitoring. An effectiveness monitoring tool had been developed, and therapists were implementing it on a trial basis for a few individuals on their caseloads. The tool was to be re-evaluated after this trial and revisions would be made, if necessary. The Facility had a sustainable system for identifying individuals who received enteral nourishment. A protocol had been developed and implemented to define this process. The Facility's Self-Assessment noted this provision was not in substantial compliance "due to not having an integrated assessment and/or discussions as well as documented plans for any modification of intake." The Monitoring Team's review identified similar issues. IDTs had reviewed individuals in the sample who received enteral nutrition, but the discussion in the IRRF Aspiration section did not address the necessary components. The Facility had developed a protocol to define the process for determining whether an individual should return to oral eating and/or receive enteral nourishment in a less restrictive manner, and if so, the pathways for accomplishing these goals. This protocol also identified what the therapist and/or dietician would discuss with IDT members upon completion of their respective assessments. The implementation of this protocol should assist the Facility in moving in the direction of reaching substantial compliance.

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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,	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 potentially met one or more of the preceding criteria. These 15 individuals were: Individual #165, Individual #190, Individual #269, Individual #233, Individual #135, Individual #114, Individual #167, Individual #62, Individual #324, Individual #53, Individual #73, Individual #235, Individual #51, Individual #14, and Individual #132. ▪ **Sample O.2** consisted of individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included eight individuals: Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, Individual #308, and Individual #76. No individuals had been discharged from the PNMT since the last review and consequently, no individuals were sampled. ▪ **Sample O.3** was comprised of individuals who received enteral nutrition. These	Substantial Compliance

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	approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	six individuals were: Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, and Individual #89. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 41 individuals (i.e., Individual #267, Individual #164, Individual #71, Individual #298, Individual #35, Individual #245, Individual #45, Individual #266, Individual #272, Individual #127, Individual #137, Individual #279, Individual #16, Individual #147, Individual #270, Individual #282, Individual #275, Individual #90, Individual #121, Individual #85, Individual #126, Individual #95, Individual #1, Individual #135, Individual #132, Individual #290, Individual #199, Individual #62, Individual #210, Individual #321, Individual #16, Individual #308, Individual #33, Individual #74, Individual #280, Individual #90, Individual #167, Individual #164, Individual #267, Individual #113, and Individual #181) 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 and/or procedures: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ State Policy 006.3 At Risk Individuals, effective 12/7/12; ▪ State Policy 003.1 Quality Assurance, effective 1/26/12; ▪ LBSSLC – IDT Process – Program Development: Physical Nutritional Management, revision date of 3/20/13; ▪ LBSSLC PNMT Guideline, revision dates of 9/13, 10/18/13, 10/21/13,	

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		10/25/13, 11/5/13, and 11/6/13; ▪ LBSSLC Protocol for Dental Department, effective date of 11/6/13; ▪ LBSSLC – Health Services: Dental Services Overview, revision and implementation date of 12/13/13; ▪ LBSSLC Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists, date of 9/16/13; ▪ LBSSLC Protocol for Process of Maintaining Lists, date of 8/30/13; ▪ LBSSLC Protocol to Identify Individuals Who Are High Risk for Aspiration Pneumonia and/or Choking, date of 11/11/13; ▪ LBSSLC Protocol for Persons Who Have Individual Specific Training Techniques, date of 10/21/13; ▪ LBSSLC – IDT Process – Active Treatment: Pulled Staff/Transfer Staff Process, revision date of 12/11/13; ▪ LBSSLC – IDT – Program Development: Occupational Therapy and Physical Therapy Services, revision date of 10/28/13; ▪ LBSSLC PNMP/Revision/Finalization, revised 12/13/13; ▪ LBSSLC Protocol for Pathway for Return to Oral Eating and/or for Least Restrictive Intake, dated 1/8/14; ▪ LBSSLC Protocol for Checking/Monitoring of Assistive Devices Individual Equipment, dated 1/8/14; ▪ LBSSLC Protocol: Nutrition Services Weight Monitoring, revision date 12/4/13; ▪ LBSSLC – Health Services: Weight Monitoring, revision date of 12/4/13; and ▪ LBSSLC Protocol: Nutrition Services Weight Monitoring, revision date of 14/4/13. LBSSLC had established PNM policies that included the following elements, though some of these were included in the DADS At-Risk Policy, Physical Nutritional Management Policy, and QA Policy: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan; ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP to be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g.,	

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		medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (not stated specifically in the policy, but clearly in practice); ▪ A system of effectiveness monitoring; ▪ Description of a sustainable QA system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns, including: 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 Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers 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 implementation of additional monitoring, as appropriate to measure the resolution of systemic issues; and ▪ 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	

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		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 all levels of risk. Based on the Monitoring Team's review of the policies, the Facility had policies and/or protocols that provided a comprehensive PNM policy, including the preceding elements. **Core PNMT Membership** The LBSSLC PNMT had the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, Speech Language Pathologist, and a Physical Therapy Assistant (PTA). Although not a requirement of the Settlement Agreement, back-up members had been identified for each position. **Consultation with Medical Providers and IDT Members** The Facility identified four medical providers who provided consultation to the PNMT: Dr. Glenn Shipley, Medical Director; Dr. Resurrection Barranda, Staff Physician; Dr. Ricardo Rodriquez, Staff Physician; and Grace Thomas, Physician Assistant. John Todd, Clinical Pharmacist was also identified as a consultant to the PNMT. The Facility-based Physical Nutritional Management policy indicated the PNMT RN was responsible for attending the daily provider morning meetings to "keep abreast of individuals' health. Based on interview, the PNMT RN provided a weekly update to members of the daily provider morning meetings on the current status of individuals on the PNMT caseload and/or presented systems issues, which required resolution. This weekly report provided the opportunity for the PNMT to seek consultation from medical providers. In addition, the PNMT RN maintained communication with medical providers through documentation in IPNs. For the eight individuals in Sample O.2 (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, Individual #308, and Individual #76 (100%), evidence was provided of medical providers' (i.e., primary care physician) participation in individuals' initial PNMT assessments. In addition, RN case managers	

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		attended meetings to provide updates for individuals on the PNMT caseload. The PNMT Meeting minutes provided updates from completed medical appointments and consultations. The RN Case Manager was able to communicate with the individual's primary care physician if questions arose during the meeting that could not be answered. In addition, the PNMT Nurse and/or a designee attended the daily provider morning meetings to receive current updates on individuals who had experienced a change in status. The PNMT Nurse also provided updates to members of the provider morning meetings on the status individuals on the PNMT caseload every Friday morning. For eight of the eight individuals (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, Individual #308, and Individual #76) (100%) in Sample O.2, evidence was provided of routine participation of other IDT members (i.e., QIDP, RN Case Manager, and Psychologist/Psychology Assistant) in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Six of six (100%) PNMT core members were licensed to practice in the state of Texas. Six of six (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** Six of six (100%) 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. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Equipment Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issue in Individuals with Developmental Disabilities (3/6/13), Advances in Motor Control and Learning for Neurological Rehab (5/29/13), Habilitation Therapies Conference (10/31/13 – 11/1/13), and Relearning Kinesia Treatment for Parkinson's Disease and Related Movement (11/6/13) for a total of 25.6 hours; ▪ SLP attended: Equipment Webinar (2/7/13), Contoured Seating Using Foam in Place Technology (2/27/13), Least Restrictive Method of Eating (4/3/13), Mealtime Miseries: Management of Complex Feeding Issues (6/7/13 – 6/8/13), Effective Sensory Diets (6/18/13), Ethics (10/8/13), Dynavox (10/8/13), and Habilitation Therapies Conference (10/31/13 – 11/1/13) for a total of 45 hours; ▪ OT attended: Autism and Sensory Processing Disorders (2/7/13), Dysphagia/GI	

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		Issue in Individuals with Developmental Disabilities (3/6/13), Equipment Webinar (2/7/13), Evaluation and Treatment of Dysphagia, Care of the Patient with Ostomy (2/13/13), Contoured Seating Using Foam in Place Technology (2/27/13), Dysphagia/GI Issue in Individuals with Developmental Disabilities (3/6/13), and Least Restrictive Method of Eating (4/3/13) for a total of at least 14 hours. The number of continuing education hours for Autism and Sensory Processing Disorders was not provided; ▪ RD attended: 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 Issue in Individuals with Developmental Disabilities (3/6/13), Least Restrictive Method of Eating (4/3/13), Introduction to GI Radiology (6/12/13), Improving Patient Outcomes: Consideration in the New Healthcare Landscape (6/25/13), Role of the RD in Health Care Reform: Managing GI Function, Wound Healing, Glycemic Control and Aspiration with Enteral Nutrition (7/10/13), The Hunger Games: Applying the Science of Satiety to Fuel Health (7/18/13), Every Breath You Take… Maintaining Pulmonology Health (7/18/13), and Habilitation Therapies Conference (10/31/13 – 11/1/13) for a total of 31 hours; ▪ RN attended: Pressure Ulcer Management: Nutrition Guidelines for Your Challenging Patients (1/23/13), Medication Administration (10/4/13), C-Difficile (10/9/13), Every Breath You Take… Maintaining Pulmonology Health (7/18/13), and Habilitation Therapies Conference (10/31/13 – 11/1/13), and Neurology –Strokes and TIA [Transient Ischemic Attack] (11/20/13) for a total of 23.5 hours; and ▪ PTA attended: 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 Issue in Individuals with Developmental Disabilities (3/6/13), Least Restrictive Method of Eating (4/3/13), Advances in Motor Control and Learning for Neurological Rehab (5/29/13), Effective Sensory Diets (6/18/13), Every Breath You Take… Maintaining Pulmonology Health (7/18/13), Functional Fitness for Older Adults (10/24/13), Habilitation Therapies Conference (10/31/13 – 11/1/13), and Parkinson's and Movement Disorders (11/6/13) for a total of 43 hours. **PNMT Meetings** Since the last onsite review, of the 24 weeks, the team met on 24 of 24 weeks (100%). Attendance by core PNMT and back-up members for 38 meetings conducted during the time frame from July 18, 2013 to December 29, 2013 was: ▪ RN: 97% attendance by core member;	

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		▪ RD: 84% attendance by core member, 8% for back-up member, 92% overall; ▪ PT: 87% attendance by core member, 5% for back-up member, 92% overall; ▪ OT: 31% attendance by core member, 60% for back-up member, 91% overall; and ▪ SLP: 97% percent attendance by core member. The attendance percentage, including core PNMT members with back-up members attending when core PNMT members were not present, exceeded 90% overall. Thirty-eight of 38 (100%) PNMT meeting minutes (July to December 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 for individuals in the sample. **Resolution of Systemic Concerns** The Facility-based PNMT Guideline had been revised since the last review to include a section on resolution of systemic issues. The PNMT Guideline identified several pathways for resolution of systemic issues, as appropriate: ▪ Presentation to the members of provider morning meeting to discuss and/or have the appropriate department address identified issues; ▪ Presentation at the Incident Management Meeting; and/or ▪ Presentation at QA/QI meetings. If warranted, a corrective action plan (CAP) would be developed and forwarded to the assigned department(s). The CAP would be implemented and monitored through the established Facility process. In addition, on a daily basis, the PNMT RN was responsible for maintaining and updating the PNM episodes spreadsheet (i.e., decubitus, fractures of long bones, choking episodes, pneumonia, emesis, weight loss, hospitalizations for respiratory compromise/GI issues/bowel obstruction/dehydration, new enteral nutrition and/or any other episodes that would impact PNM status) to monitor for trends. The PNMT RN was responsible for reporting the results of the Episode Tracker on a weekly basis. In addition, if the PNMT RN determined that an individual met any of the PNMT referral criteria, members of the IDT would be notified. All communication between the PNMT RN with the IDTs was shared with PNMT members. This was documented in PNMT minutes. In addition, this information was discussed in the provider morning meetings. The PNMT reports submitted for review in the Presentation Book for Section O (i.e., 11/8/13, 11/14/13, and 11/31/13) noted: "there were currently no updates on the Episode Tracker." The LBSSLC – IDT Progress – Program Development: Physical Nutritional Management policy for data collection stated there was a quality improvement process that assessed data for trends. However, no PNMT trend analysis was submitted for review.	

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		PNNT minutes also addressed the status of systemic concerns. For example: ▪ PNMT core meeting (i.e., 7/25/13) discussed that all individuals who were recommended to receive a Modified Barium Swallow (MBS) study would be reviewed by the PNMT. The PNMT SLP would also attend all MBS studies. In summary, the Facility had achieved substantial compliance with this subsection. At the time of the Monitoring Team's review: the Facility had policies, protocols and guidelines which incorporated necessary elements; the PNMT had the required core members as outlined in the Settlement Agreement; PNMT members had exceeded the annual requirement for continuing education and the continuing education completed was relevant to the physical and nutritional supports and was transferrable to the population served; the PNMT was consulting with medical providers and IDT members in a variety of ways; the PNMT was meeting on a regular basis; and the PNMT had established a system to resolve identified systems issues.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Identification of PNM Risk** The Facility now had a sustainable system to maintain lists that identified individuals who required mealtime assistance, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). Since the last review, the Facility had developed a protocol that described the process for maintaining master lists that identified individuals with physical or nutritional management problems. These master lists included: ▪ Individuals who required mealtime assistance; ▪ Individuals who required positioning assistance associated with swallowing activities; ▪ Individuals who had difficulty swallowing; and ▪ Individuals at risk of choking or aspiration. This protocol also defined the process for two additional lists: individuals who had received a Modified Barium Swallow (MBS) study, and individuals who receive enteral nourishment. This protocol was implemented on 9/30/13 and revised on 11/11/13. One staff member was identified as the "Master Keeper" of these lists. A back-up keeper also was identified. Pathways were defined for therapists and support staff to provide information to the Master Keeper for individuals who should be added and/or deleted from these lists. For example, the HT Clerk reviewed risk ratings on a monthly basis to determine if there had been any changes for individuals' risk ratings for choking and/or aspiration, and the lists were modified as appropriate. This protocol defined how the Facility would accurately identify individuals with PNM	Noncompliance

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		concerns and how these lists would be validated by the Master Keeper, therapists, and therapy supports for accuracy. These lists should ensure the Facility identifies individuals with PNM problems thereby enabling the provision of adequate physical and nutritional interventions. **<u>Physical and Nutritional Management Team Referral Process</u>** Since the last review, the Facility had implemented a new PNMT referral form, effective 10/1/13. If the IDT and/or the primary care physician determined a referral was indicated, the PNMT referral form was to be completed with rationale for the referral and forwarded to the PNMT RN. The PNMT would review the following in making a decision to accept an individual on their caseload: ▪ Existing assessments and recommendations (i.e., OT, PT, Communication, Nursing, History and Physical); ▪ Previous interventions by the IDT including ISP, ISPA, IRRF, IHCP, and other existing action plans; ▪ Data collection and IDT monitoring results; ▪ PNMP, dining plans and communication dictionaries; and ▪ Record review, as applicable. The Facility Self-Assessment reported that the number of referrals to the PNMT had increased since the implementation of the PNMT referral form. This was a positive development. However, a review of individuals in Sample O.1 indicated there were individuals who should have been referred to the PNMT. Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT, based on the Facility policy. More specifically: ▪ Twelve of the 15 individuals (i.e., Individual #190, Individual #167, Individual #62, Individual #324, Individual #53, Individual #73, Individual #14, Individual #235, Individual #51, Individual #135, Individual #233, and Individual #132) did not meet the PNMT referral criteria. ▪ Three of the 15 individuals in Sample O.1 should have been referred to the PNMT. Of these three, none (0%) were referred to the PNMT. o One individual had experienced unplanned weight loss (i.e., Individual #165) in this sample. Based on interview with the HT Director and the Chief Clinical Dietician, there were two Facility policies and one protocol to address weight loss: LBSSLC – Health Services: Weight Monitoring; LBSSLC – Health Services: Clinical Nutrition Services; and LBSSLC Protocol: Nutrition Services Weight Monitoring. The Weight Monitoring policy identified the significant weight changes/variances that were in alignment with the PNMT referral criteria for weight gain/loss. The Protocol: Nutrition Services Weight Monitoring defined the responsibilities of the individual's dietician.	

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		Individual #165's IRRF, dated 11/18/13, stated: "Weight trends indicated significant weight loss: 5.1% loss in 1 month, 9.8% loss in 3 months, 12.8% in 6 months and 18.9% loss (30 lbs) since October 2012." It was unclear why the IDT members ranked him at medium risk for weight. A subsequent ISPA, dated 12/13/13, noted: "per weekly weights, [Individual #165] has continued to lose weight." Individual #165's IDT should have initiated a Change of Status IRRF and IHCP review. It did not appear the IDT was successfully addressing his weight loss. Individual #165 should have been referred to the PNMT. o Two individuals had been hospitalized: ▪ On 8/30/13, Individual #114 was discharged from the hospital with diagnoses of urinary tract infection and aspiration pneumonia. An ISPA, dated 9/30/13, noted: "the IDT did not make a referral to PNMT at this time however; PNMT will monitor [Individual #114]." It was unclear why the PNMT would be monitoring Individual #114 if he had not been referred to the PNMT and was not on the PNMT caseload. However, the IDT did not complete a Change of Status IRRF and/or make revisions to the IHCP. Given the diagnosis of aspiration pneumonia, Individual #114 should have been referred to the PNMT ▪ The aspiration section of Individual #269's IRRF, dated 10/8/13, indicated: "[Individual #269] has been hospitalized 4 times this year for Aspiration Pneumonia." Individual #269's ISPA, dated 12/10/13, noted she was hospitalized from 12/6/13 to 12/9/13. The hospital diagnosis was bacterial pneumonia. Due to her history of aspiration pneumonia and another diagnosis of pneumonia, Individual #269 should have been referred to the PNMT. Two individuals had received a feeding tube sine the last review. ▪ Two of two individuals (100%) (i.e., Individual #43 and Individual #171) 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. The following was not applicable, because no individual had received an emergency tube placement since the last review: ▪ ___ of ___ (%) individuals 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.	

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		PNMT Assessment For the eight individuals in Sample O.2, seven of eight PNMT assessments (88%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Individual #128's PNMT assessment indicated she was referred to the PNMT on 5/20/13, and the assessment was initiated on 7/25/13. Eight of eight (100%) 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 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: ▪ Eight of eight (100%) contained date of referral by the IDT; ▪ Eight of eight (100%) contained the date the assessment was initiated; ▪ Eight of eight (100%) contained evidence of review and analysis of the individual's medical history; ▪ Eight of eight (100%) identified the individuals' current risk rating(s), including the current rationale; ▪ Eight of eight (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Eight of eight (100%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Seven of eight (88%) (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, and Individual #308) contained assessment of current physical status; ▪ Seven of eight (88%) (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, and Individual #308) contained assessment of musculoskeletal status; ▪ Seven of eight (88%) (i.e., Individual #128, Individual #43, Individual #33, Individual #284, Individual #280, Individual #191, and Individual #308) contained evaluation of motor skills; ▪ Two of eight (25%) (i.e., Individual #128 and Individual #33) contained evaluation of skin integrity; ▪ Eight of eight (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Eight of eight (100%) contained evaluation of current adaptive equipment; ▪ Eight of eight (100%) contained nutritional assessment, including, but not	

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		limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ None of eight (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ Three of three (100%) (i.e., Individual #128, Individual #43, and Individual #191) identified residual thresholds, if enterally nourished. This metric was not applicable for five individuals (i.e., Individual #33, Individual #284, Individual #280, Individual #308 and Individual #76) as they ate orally; ▪ Eight of eight (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ Two of eight (25%) (i.e., Individual #128 and Individual #43) contained respiratory status; ▪ Eight of eight (100%) contained evidence of review/analysis of lab work; ▪ One of eight (13%) (i.e., Individual #128) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Eight of eight (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ Five of five (100%) (i.e., Individual #43, Individual #33, Individual #191, Individual #308, and Individual #76) contained oral hygiene status. For the remaining three individuals, the reasons for PNMT referral were not related to oral hygiene status; ▪ Eight of eight (100%) contained evidence of observation of the individual's supports at their residence and day/work programs. ; ▪ Eight of eight (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Eight of eight (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Eight of eight (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; ▪ Eight of eight (100%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ Eight of eight (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ One of eight (13%) (i.e., Individual #33) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Eight of eight (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's	

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		PNMP); ▪ Eight of eight (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ Five of the eight (62%) (i.e., Individual #128, Individual #43, Individual #191, Individual #308, and Individual #76) contained signatures with dates. Therapist signatures were present for the remaining three individuals (i.e., Individual #33, Individual #284, and Individual #280), but dates were missing by some therapists' signatures. PNMT assessments continued to contain the majority of components necessary. Missing components for some individuals' PNMT assessments as presented above included: assessment of physical status, musculoskeletal status, motor skills, skin integrity, respiratory status, evaluation of potential or actual drug/drug and drug nutrient interactions, measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT, and the assessment completion date by a therapist. **Integration of PNMT Recommendations into IHCPs and/or ISPs** For none of the eight (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs, and IHCPs. PNMT assessment recommendations were integrated in PNMP Follow-Up documentation that addressed recommendations and plans. However, PNMT recommendations and plans were not integrated into IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In eight of the eight (100%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ For two of the three (67%) individuals (i.e., Individual #43 and Individual #191) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. ▪ In none of the eight (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 eight of the eight (100%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. ▪ In eight of the eight (100%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In eight of the eight (100%) individuals' plans reviewed, the plans defined	

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		triggers. ▪ In eight of the eight (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 eight of eight (100%) 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. ▪ In eight of the eight (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** Based on interview with the HT Director, no individuals had been discharged from the PNMT since the last review. Consequently, the following were not reviewed, but will be in future reviews for individuals discharged from the PNMT: ▪ ____of the ____ (%) individuals had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ ____ of the ____ (%) individuals' discharge summary/action plans provided objective clinical data to justify the discharge. ▪ ____ of the ____ (%) individuals' ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ ____ of the ____ (%) individuals' ISPA documentation and/or action plan included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the Facility had a sustainable system to maintain and update lists to identify individuals having physical or nutritional management problems. On 10/1/13, a PNMT referral form was implemented, which had increased the number of individuals referred to the PNMT. However, some individuals in Sample O.1 should have been referred to the PNMT, but were not. The PNMT assessments and action plans included many of the necessary components. The Facility Self-Assessment indicated: "this provision is not in substantial compliance; ensuring ISPA is documented and filed and integration into the IHCP are not consistently completed." This was consistent with the Monitoring Team's finding. To move in the direction of achieving substantial compliance within this section the Monitoring Team recommends the Facility consider the following focus: ensure individuals who meet the PNMT referral criteria are referred to the PNMT with an emphasis on individuals who have experienced respiratory concerns; and ensure PNMT assessments and IHCPs include all necessary components. The Facility remained out of	

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		compliance with Section O.2.	
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** One hundred and sixty-five (81%) of the 204 individuals living at LBSSLC had a PNMP. The Facility had implemented a pre-ISP process that occurred three months prior to the ISP. During this meeting, the IDT met to plan for the annual ISP meeting. This meeting included the completion of a form that identified IDT members required to attend the annual ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation for required attendance were reviewed. Four individuals did not have pre-ISP documentation available (i.e., Individual #190, Individual #324, Individual #73 and Individual #51). The ISP signature sheet for Individual #132 was from the previous annual ISP, and, therefore, was not current for his most current annual ISP meeting. For these individuals, the IDT member attendance was not reviewed. For the remaining ten individuals, six individuals' ISPs attendance sign-in sheets (i.e., Individual #165, Individual #233, Individual #114, Individual #62, Individual #53, and Individual #235) noted the IDT members required to attend the ISP meeting were present as required according the pre-ISP attendance required documentation. However, these six individuals' pre-ISP meeting documentation did not provide adequate justification to support non-attendance of therapists and/or a dietician. Some examples of insufficient justification included statements such as: ▪ An HT representative may represent this discipline; ▪ Assessment current and remains accurate; ▪ HT rep can provide information; ▪ Assessment only; and ▪ One HT representative as assigned. 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 PNMT, 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. The absence of team members (i.e., RD, OT, PT, SLP, Dental, psychologist, medical provider and direct support professional) impacted the team's ability to provide adequate input in a review of the effectiveness of an individual's PNMP and the need for revision of an individual's PNMP, if appropriate. The review of an individual's PNMP should be an important factor when identifying disciplines that should be present during the annual ISP meeting. None of 14 (0%) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT in the annual ISP meeting. Each individual's ISP had a section for the review and	Noncompliance

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		approval of the PNMP. The IDT discussion should include evidence of review of effectiveness as well as accuracy, updates/revisions agreed upon by the team, and specified changes required with rationale. The Facility Self-Assessment acknowledged: "this provision is not in compliance as further integration and discussion is needed to occur at ISP meeting." **PNMP Format and Content** Fourteen PNMPs for individuals in Sample O.1 were reviewed. Individual #51 had a dining plan, but did not have a PNMP. The review found the following: ▪ PNMPs for 14 of 14 (100%) individuals were current within the last 12 months. ▪ PNMPs for 14 of 14 (100%) individuals included a list of risk levels and triggers; ▪ In 14 of 14 (100%) PNMPs, there were large and clear photographs with instructions. ▪ Twelve of 14 (86%) PNMPs (i.e., Individual #269, Individual #233, Individual #135, Individual #114, Individual #167, Individual #62, Individual #324, Individual #53, Individual #73, Individual #235, Individual #14, and Individual #132) listed the adaptive equipment required by the individual with rationale. Individual #165 and Individual #190's PNMPs listed adaptive equipment, but did not include the rationale. ▪ Eight of the 15 individuals used a wheelchair as their primary mobility. In eight of eight (100%) PNMPs for individuals who used a wheelchair as their primary mobility (i.e., Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, Individual #53, Individual #14 and Individual #132), positioning instructions for the wheelchair, including written and pictorial instructions were provided. ▪ In of 14 of 14 PNMPs (100%), positioning was adequately described per the individuals' assessments. A review of OT/PT assessments showed they did provide a description of alternate positioning, including safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 14 of 14 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. ▪ In two of 14 (14%) PNMPs (i.e., Individual #190 and Individual #132), bathing instructions were provided. For the remaining individuals, staff instructions did not consistently include strategies, independence, and level of staff assistance required. ▪ In one of 14 (7%) PNMPs (i.e., Individual #132), toileting-related instructions were provided, including check and change. For the remaining individuals, instructions were not provided to identify the level of independence, degree of safe elevation, and/or level of staff assistance required during toileting. ▪ In 14 of 14 (100%) PNMPs, handling precautions or movement techniques were	

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		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. ▪ Five individuals had feeding tubes with no oral intake (i.e., Individual #269, Individual #114, Individual #167, Individual #62 and Individual #324). Five of five (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 15 of 15 (100%) PNMPs/dining plans, position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Ten individuals ate orally within this sample (i.e., Individual #165, Individual #190, Individual #233, Individual #135, Individual #53, Individual #73, Individual #235, Individual #51, Individual #14 and Individual #132). o In 10 of 10 (100%) PNMPs/dining plans, for individuals who ate orally, diet orders for food texture were included. o In 10 of 10 (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In four of 10 (40%) (i.e., Individual #190, Individual #135, Individual #53, and Individual #235) 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 six individuals' dining plans listed adaptive equipment, but no rationale was provided. ▪ In 14 of 14 (100%) PNMPs, medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In eight of 14 (57%) (i.e., Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, Individual #53, Individual #73, and Individual #132) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. The remaining six individuals' PNMPs did not include general positioning and/or brushing instructions. ▪ Fourteen of 14 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** The LBSSLC - IDT – Program Development: Occupational Therapy and Physical Therapy Services policy stated: "the PNMP is developed with IDT input and/or revised with IDT	

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		input at the annual ISP meeting and as often as needed through an ISPA." ▪ For the eight individuals in Sample O.1 with PNMPs for whom the IDT identified changes were needed to the PNMP after the annual ISP meeting, one of the eight individuals' revised PNMPs (13%) (i.e., Individual #190) had been reviewed and approved by the IDT in an ISPA meeting. Seven individuals did not have an ISPA meeting to present the proposed revisions to IDT members (i.e., Individual #132, Individual #14, Individual #114, Individual #324, Individual #233, Individual #51, and Individual #235). ▪ For individuals for whom the PNMP was revised, there was supporting documentation that one of the eight (13%) (i.e., Individual #190) individuals' revised PNMPs had been implemented. In summary, progress continued to be made with individuals' PNMPs having more of the necessary components. To achieve substantial compliance with this section, IDTs need to review and document their decisions about PNMPs, and missing elements should be added to PNMPs. In addition, when changes are made to PNMPs, the IDTs need to discuss and approve changes through an ISPA. 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** Based on the Monitoring Team's observations during the onsite review, dining plans were accessible for staff reference and staff referred to individuals' dining plans during mealtime observations. During the Monitoring Team's onsite review, a member of the Monitoring Team, the Active Treatment Coordinator, and the Safety Officer (i.e., key staff in the Facility's mealtime coordination training and oversight initiatives) completed mealtime observations in the following homes: Rose, Violet (i.e., two meal observations), Elm, Birch, Maple, Zinnia, Canna, and Iris. These observations occurred in dining rooms during lunch and/or dinner. Twenty-six individuals were observed in these homes (i.e., Individual #267, Individual #164, Individual #71, Individual #298, Individual #35, Individual #245, Individual #45, Individual #266, Individual #272, Individual #127, Individual #137, Individual #279, Individual #16, Individual #147, Individual #270, Individual #282, Individual #275, Individual #90, Individual #121, Individual #85, Individual #126, Individual #95, Individual #1, Individual #135, Individual #132, Individual #290). The following summarizes the results of these observations: ▪ No mealtime errors were observed in Rose, Elm, Birch, Maple, Zinnia, and Canna. For example, Mealtime Coordinators (MTCs) and table captains were present and implementing their responsibilities correctly (e.g., prompting individuals to sit up, prompting individuals to slow their eating pace, etc.), individuals were positioned correctly in their wheelchairs and dining chairs, the prescribed adaptive equipment was available, and staff were following dining plan presentation techniques.	Substantial Compliance

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		▪ During the first visit to Violet, concerns were noted with regard to the implementation of dining plans (i.e., for Individual #35, Individual #245, Individual #45, and Individual #266). For example, dining plans were not accessible and/or staff were not referring to the dining plan, the MTC was not providing coaching and mentoring to table captains to correct staff who were not following dining plan presentation techniques, and individuals were not positioned correctly in their wheelchairs and/or regular dining chairs, etc. The Active Treatment Coordinator requested the Monitoring Team make a second visit to Violet. Based on an interview with the Active Treatment Coordinator, he had worked with the MTC and residential staff to correct the deficiencies observed during the first observation. In addition, the Residential Coordinator from Aspen, who was actively involved in the implementation of the Mealtime Coordination initiative, was present to provide coaching and mentoring to the Mealtime Coordinator. The second mealtime observation in Violet was substantially improved. The Active Treatment Coordinator indicated that prior to the Monitoring Team's visit, through video surveillance monitoring, it had been determined and key administrative staff had been made aware that Violet had not achieved the established threshold for mealtime monitoring. Consequently, Violet had been required to implement a plan of correction. This was evidence that the Facility had a sustainable mealtime coordination and oversight system, which had already identified problems in this home. ▪ Similarly, the mealtime observation in Iris revealed the MTC was not providing coaching and/or mentoring to the table captain. Individual #290 was eating at too fast a pace, and the table captain was not following the presentation technique to limit his bite size. Based on an interview with members of the Mealtime Coordination workgroup (i.e., ADOP, Active Treatment Coordinator, Safety Officer, Facility OT, and Director of HT), after mealtime observations, these members acknowledged that these mealtime monitoring results for this home, as well as Violet, had scored below the established threshold, which required a plan of correction. These observations were not a surprise to members of the Mealtime Coordination workgroup. The implementation of the Mealtime Coordination initiative had already identified these homes as requiring more assistance to correct staff engaging in unsafe mealtime practices. Twenty-one of the 26 (81%) individuals (i.e., Individual #267, Individual #164, Individual #71, Individual #298, Individual #272, Individual #127, Individual #137, Individual #279, Individual #16, Individual #147, Individual #270, Individual #282, Individual #275, Individual #90, Individual #121, Individual #85, Individual #126, Individual #95, Individual #1, Individual #135, and Individual #132) dining plans were implemented as written. Those that were not included: Individual #35, Individual #245, Individual #45, and Individual #266 from the first observation in Violet; and Individual	

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		#290 in the mealtime observation in Iris. As discussed above, the key staff for mealtime coordination and oversight were aware of mealtime problems that required correction in Violet and Iris prior to the Monitoring Team's visit. These homes had not achieved the established compliance threshold of 80% and were working on a plan of correction. The plans of correction were initiated on December 9, 2013. Meals were to be monitored for the next 30 days. In addition, members of the MTC workgroup were to assist with correction of identified monitoring deficiencies. Although the mealtime observations in Violet and Iris identified mealtime errors, it was positive that the Facility's mealtime coordination and oversight system had identified Violet and Iris as problematic homes and had taken steps to ensure these homes would meet the established mealtime monitoring thresholds. Since the last review, the Facility had implemented significant revisions in the Mealtime Procedures training curriculum with an emphasis on dining plans and Home Procedures as well as other initiatives. Additional information on these initiatives is described in further detail with regard to Section O.5. During this review, the percentage of mealtime observations that showed correct implementation of dining plans (i.e., 81%) was a significant improvement from the last review in which the mealtime observations showed correct implementation 0% of the time. The Facility is to be commended for their commitment to continue to make revisions to their Mealtime Coordination system with the goal of ensuring staff do not engage in unsafe mealtime practices, and striving to support a mealtime environment that supports the independence of individuals. Based on observations the Monitoring Team conducted with the PNMT PTA, PNMT OT, and Facility therapists: ▪ Five of six individuals (83%) (i.e., Individual #199, Individual #62, Individual #210, Individual #321, and Individual #16) were positioned correctly in their seating systems. Individual #308 was not correctly positioned in his wheelchair. The staff present had received individual-specific training for his wheelchair positioning, but he had not positioned Individual #308 correctly; ▪ Eight of nine (89%) individuals' alternate positioning plans (i.e., Individual #33, Individual #74, Individual #280, Individual #90, Individual #167, Individual #164, Individual #267, and Individual #113) were implemented as written. Individual #181's bed position was not consistent with the written instructions. ▪ Two of two (100%) (i.e., Individual #267and #71) transfer plans was implemented as written. Staff implementation of medication administration, transfers, bathing, and oral hygiene were not observed during this review, so the following were not completed. However, they will be assessed during upcoming reviews, and are necessary for substantial compliance to be maintained:	

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		▪ ____ of ____ (%) oral hygiene plans were implemented as written. ▪ ____ of ____ (%) bathing plans were implemented as written. ▪ In ___ of ____ observations of medication administration, the nurse followed procedures in the PNMP. The Facility was in substantial compliance with this subsection. This was due to the fact that the Monitoring Team's onsite observations showed fairly consistent implementation of dining plans and PNMPs, and, when concerns existed, Facility staff with the Monitoring Team independently noted similar concerns. The Facility had a process in place to identify and respond to concerns with regard to implementation of PNMPs and dining plans, and as illustrated during the Monitoring Team's review, took action to correct noted deficiencies. This represented a functioning, self-correcting system to prevent and ameliorate problems with staff's implementation of dining plans and PNMPs, thus reducing individuals' risk.	
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.	**New Employee Orientation (NEO)** The Facility had developed and implemented a PNM foundational competency-based training curriculum that contained the following components, and it continued to be considered comprehensive: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. LBSSLC New Employee Orientation was provided on a monthly basis. HT training sessions were provided across three days for a total of 11.5 instructional hours. All new employees were required to successfully complete PNM foundational competency performance check-offs. The passing score for PNM competency testing was 80% or above. The categories/positions of staff that required PNM-related NEO training included all direct support staff (i.e., residential, programs, vocational, recreational, and active treatment staff) and professional/clinical staff (i.e., psychology, QIDPs, and nursing staff). The Facility Self-Assessment, updated 12/20/13, indicated from 5/1/13 to 11/15/13, 108 of 108 new employees (100%) successfully passed the PNM competency performance check-offs required prior to working with individuals. **PNM Core Competencies for Current Staff** The Facility Self-Assessment and pre-review documentation indicated that Competency	Substantial Compliance

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		Training and Development (CTD) participation reports from 5/1/13 to 11/15/13 indicated 305 of 308 current staff (99%) required to complete PNM foundational training had successfully completed PNM performance check-offs. Twenty-two of 22 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. **Annual Refresher Training** As stated above, 305 of 308 staff (99%) of Facility staff that required training had completed annual refresher competency-based training and performance check-offs within the last 12 months. In September 2013, this training had become a mandatory refresher PNM foundational training that staff will be responsible for completing on an annual basis. **Individual Specific Training** The Facility submitted a "Protocol to Identify Individuals Who Require Individual Specific Competency-Based Training and Are High Risk for Aspiration Pneumonia and/or Choking." Fifty-four (54) individuals, who were at high risk for aspiration pneumonia and choking, were identified by the placement of a green dot on their PNMPs and dining plans. Therapists determined that 28 individuals would require individual-specific training outside of the content of PNM foundational training. Staff were required to have individual-specific competency-based training prior to working with these 28 individuals. These individuals were identified by a red dot on their PNMPs and dining plans. The red dot had an overlay of "IS," which was the abbreviation for individual-specific. This red dot was to alert managers and staff that individual-specific training had to be completed before staff were able to work with an individual. The LBSSLC – IDT Process – Active Treatment: Pulled Staff/Transfer Staff Process further defined the responsibilities of the Residential Coordinator. The Residential Coordinator was responsible for ensuring that all pulled staff were trained on PNMPs and dining plans, and not assigned to provide supports to anyone who had been identified with a red dot unless their name was listed as having successfully completed individual-specific competency-based training. The list of staff that had been trained for individuals requiring individual-specific training was placed in Individuals' Notebooks. The Facility Protocol for Persons Who Have Individual-Specific Training Techniques, dated 10/21/13, defined the system for the development and implementation of the provision of individual-specific training. The protocol outlined the specific responsibilities of clinical licensed therapists, PNMP Coordinators, and Residential Coordinators. Each home was responsible for having a notebook that contained a staff	

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		roster of who required and had successfully completed individual-specific training, copies of individuals' PNMPs and dining plans, copies of staffs' completed performance check-offs, and copies of PNMP Coordinators' completed performance check-offs. Training documentation was reviewed for six individuals in Sample O.1 (i.e., Individual #167, Individual #62, Individual #324, Individual #53, and Individual #14) and one individual in Sample O.2 (i.e., Individual #33). These six individuals were identified by the placement of a red dot on their PNMPs and dining plans, which alerted residential managers and direct support professionals that staff were required to have successfully completed individual-specific competency-based training prior to providing prescribed supports. These documents were reviewed to determine if there had been an exchange of the information included in the PNMP. The following summarizes the findings: ▪ Documentation showed that for 23 of 23 staff (100%) assigned to Individual #167, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 23 of 23 staff (100%) assigned to Individual #62, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 26 of 26 staff (100%) assigned to Individual #53, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 24 of 24 staff (100%) assigned to Individual #324, there was evidence of exchange of the information included in the PNMP prior to the provision of services; ▪ For 23 of 23 staff (100%) assigned to Individual #14, there was evidence of exchange of the information included in the PNMP prior to the provision of services; and ▪ For 23 of 23 staff (100%) assigned to Individual #33, there was evidence of exchange of information included in the PNMP prior to the provision of services. For staff assigned to six individuals in Samples O.1 and O.2, records were reviewed to determine if staff assigned had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services. The following summarizes the findings: ▪ The 23 of 23 staff (100%) assigned to Individual #167 had completed competency check-offs in all specialized components of the PNMP (i.e., non-foundational skills for an ankle brace) prior to the provision of services; ▪ The 23 of 23 staff (100%) assigned to Individual #62 had completed competency check-offs in all specialized components of the PNMP (i.e., non-foundational skills for transfer and wheelchair positioning) prior to the provision of services; ▪ The 26 of 26 staff (100%) assigned to Individual #53 had completed competency	

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		check-offs in all specialized components of the PNMP (i.e., non-foundational skills for modified sight guide/AAC) prior to the provision of services. ▪ The 24 of 24 staff (100%) assigned to Individual #324 had completed competency check-offs in all specialized components of the PNMP (i.e., non-foundational skills for re-positioning and mechanical lift transfer by three staff) prior to the provision of services. ▪ The 23 of 23 staff (100%) assigned to Individual #14 had completed competency check-offs in all specialized components of the PNMP (i.e., non-foundational skills for the dining plan) prior to the provision of services. ▪ The 23 of 23 staff (100%) assigned to Individual #33 had completed competency check-offs in all specialized components of the PNMP (i.e., non-foundational skills for sensory interventions) prior to the provision of services. There were 22 approved trainers for PNM individual-specific training. This included four occupational therapists, three physical therapists, one physical therapy assistant (PTA), four speech language pathologists, three registered dieticians, and seven PNMP Coordinators. 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 other staff on the PNMPs/Dining Plans. The Facility had a written procedure (i.e., Protocol for Persons Who Have Individual Specific Training Techniques, dated 10/21/13) that defined the validation process used to confirm that staff responsible for training other staff were competent to assess other staff's competency. Based on documentation the Facility provided, twenty-two of 22 staff (100%) responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundation skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining plan. The Facility had developed and implemented a sustainable system for the identification of individuals whose PNMP strategies required staff received individual-specific training, including identification of these individuals by the placement of a RED dot on PNMPs and dining plans, and procedures for management staff to follow in assigning staff to work with these individuals. **<u>Facility Mealtime Coordination Committee Initiatives</u>** The Facility continued to revise and improve their Mealtime Coordination system. Since the last review, the Facility Mealtime Workgroup decided Mealtime Coordinators were not being successful, because all staff were not aware of everyone's roles and responsibilities during mealtimes. To ameliorate these concerns the following initiatives	

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		were completed: ▪ The Mealtime Procedure training curriculum was revised to place more emphasis on following the dining plan and Home Procedures; ▪ A four-hour competency-based training incorporating these revisions had been completed for 99% of direct support professionals (368 staff). This training included a demonstration check-off to test staff skills on following the dining plan and diet card; ▪ Home Procedures for all homes had been revised to a standard format to be more user-friendly to MTCs; ▪ Training was provided to Residential Coordinators on Home Procedures; ▪ 73% (70 of 96) of MTCs had successfully completed the competency performance checks; ▪ A video mealtime monitoring process was formalized and initiated in September 2013. A monitoring form was developed, and a tracking system was developed to report mealtime monitoring results to Residential Coordinators. Each of the 13 monitoring indicators were given an individual percentage score. These individual scores were tabulated in a monthly percentage report by home. If a homes' mealtime monitoring scores were 75% or below, a plan of correction was required to be developed. This threshold recently had been increased to 80% or below. Based on interviews with the Assistant Director of Programs, Active Treatment Coordinator, Safety Officer, Director of HT, and an Occupational Therapist, the focus of the Mealtime Workgroup over the next six months will include the following: focus on monitoring during snack time, education of professional staff; and continuing to raise the monitoring threshold score. If mealtime monitoring scores falls on or below this revised threshold, a plan of correction will be required. The Facility had implemented a comprehensive PNM foundational training program for new employees and veteran staff. In September 2013, mandatory PNM foundational annual refresher training had been initiated. The Facility therapists had identified 28 individuals who required PNMP individual-specific training, and training had been provided to staff assigned to work with them. There was a sustainable system developed and implemented for the provision of individual-specific training for staff. The Facility was in substantial compliance with Section O.5.	
O6	Commencing within six months of the Effective Date hereof and with	**<u>Facility's System for Monitoring of Staff Competency with PNMPs</u>** The LBSSLC Compliance/Efficacy Monitoring Guideline, dated 9/16/13, had been	Noncompliance

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	full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	developed since the last review. It defined the process utilized to implement compliance monitoring for individuals with high or medium risks directly associated to PNM supports. Individuals identified at high risk (i.e., aspiration, choking, falls, fractures, respiratory, and skin integrity) were to be monitored monthly and individuals at medium risk were to be monitored quarterly. The HT Administrative Assistant developed a monthly monitoring schedule. The Facility used the following compliance monitoring tools: ▪ LBSSLC Mealtime Compliance Monitoring, dated 4/15/13; and ▪ PNMP Compliance Monitoring, dated 4/15/13, for positioning, meal, snack, medication administration, oral care, bathing, lifting/transfer, and communication. The Compliance Monitoring forms had instructions, and there were additional indicators included in the instructions for positioning (i.e., wheelchair, positioning, bed, and recliner), lifting/transfer, meals and communication. However, these additional indicators were not included on the Compliance Monitoring forms. There were no additional monitoring indicators for medication administration, bathing, and oral care. Without such discrete indicators, adequate information would not be available to identify individual and/or systemic issues requiring correction. A spreadsheet with the following fields tracked Compliance Monitoring results: ▪ General information (i.e., monitor focus, date, time); ▪ Individual (home, client name); ▪ Name of observer/monitor; ▪ Results of four Staff Observation indicators; ▪ Results of five Staff Drill indicators; ▪ Compliance score; and ▪ Pass/fail status. This spreadsheet showed that monitoring had been completed from July to December 2013 in the following areas: meals, positioning, bathing, and medication administration. The monitoring data would have allowed the following breakdown of information to be calculated. However, the Facility did not provide summary/aggregate data, and the data was extensive and the Monitoring Team did not attempt to calculate the data to enable the scoring of the following indicators. The Facility should have a mechanism to quickly determine if a sufficient number of audits have been done of the following various types of activities as required by policy and across all three shifts. These following indicators will be reviewed during the next review: ▪ ____ of the ____ monitoring forms (%) focused on oral intake (meals and snacks); ▪ ____ of the ____ monitoring forms (%) focused on bathing;	

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		▪ ____ of the ____ monitoring forms (less than 1%) focused on medication administration; ▪ ____ of the ____ monitoring forms (%) focused on oral care; and ▪ ____ of the ____ monitoring forms (%) focused on positioning; ▪ ____ % occurred during first shift (Note: two monitoring events did not designate the shift during which the monitoring occurred); ▪ ____ % occurred during second shift; and ▪ ____ % occurred during third shift. In order to address 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. Furthermore, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties and/or times of day (i.e., oral care, snacks). The Facility should produce a report that provides data to address these indicators, as well as define the specific PNMP monitoring that should occur for individuals at high risk who require monthly monitoring and individuals who require quarterly monitoring. **Monitoring for Individuals in Samples** Nine of the 15 individuals in Sample O.1 (i.e., Individual #53, Individual #190, Individual #114, Individual #269, Individual #167, Individual #14, Individual #62, Individual #132, and Individual #324) were rated as being at high risk for one or more of the identified PNM risk indicators (i.e., aspiration, choking, falls, fractures, respiratory concerns, and/or skin integrity). The frequency of PNMP monitoring for individuals at high risk, as established by the Facility, was monthly. Two of the nine individuals (22%) (i.e., Individual #62 and Individual #14) were monitored on a monthly basis. Some of these individuals received monthly communication monitoring, which was not applicable in this section. The remaining six individuals (i.e., Individual #233, Individual #235, Individual #73, Individual #165, Individual #135, and Individual #51) were ranked at medium risk for one or more of the identified PNM risk indicators. Three of the six individuals (50%) (i.e., Individual #51, Individual #233, and Individual #165) were monitored at the frequency established in the Facility protocol. For none of eight (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.	

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		The Compliance Monitoring database identified a pass/fail compliance score for each type of monitoring completed. There was no cumulative score that identified the number of monitoring forms that received a failing score. The Monitoring Team was not able to discern from the data presented if adequate follow-up had been completed for monitoring forms that received a failing score. The Facility should identify ways to present data that identifies the number of problems identified (i.e. monitoring that received a failing score) and the total number of monitoring forms completed during a specific month. In addition, data should be provided to confirm adequate follow-up was completed. The Monitoring Team did not attempt to calculate the data to enable the scoring of 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. 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. At the time of the Monitoring Team's review, the Facility had a policies and/or procedures that described the current monitoring system to test staff's implementation of PNMPs as listed below: ▪ LBSSLC Compliance Efficacy Monitoring Guideline, dated 9/16/13; ▪ LBSSLC – IDT – Program Development: Occupational Therapy and Physical Therapy Services, revision date of 10/28/13; ▪ LBSSLC – IDT Process – Program Development: Physical Nutritional Management, revision date of 3/20/13; ▪ LBSSLC PNMT Guideline, revision dates of 9/13, 10/18/13, 10/21/13, 10/25/13, 11/5/13, and 11/6/13; and ▪ LBSSLC Protocol to Identify Individuals Who Are High Risk for Aspiration Pneumonia and/or Choking, date of 11/11/13. These policies and/or procedures included: ▪ 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;	

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		▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific enhanced PNMP 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 noncompliance with PNMPs and therapy programs. In summary, the Facility had developed and implemented a PNM monitoring policy with operational guidelines, including the necessary components. PNMP monitoring was not occurring at the established frequency for individuals with high and/or medium PNM risks. Additional work needed to be done, including an analysis of monitoring results to identify the number of monitoring forms completed within a specified time period for oral intake, bathing, medication administration, oral care, and positioning. In addition, this data should identify the percentage of monitoring forms that were completed across first, second and third shifts. Although the Facility had done work to identify and correct problems, the Facility needed to have a mechanism to aggregate information regarding the actions needed and actions taken to correct deficiencies identified through the monitoring process. 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** The Facility's Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists protocol, dated 9/16/13, defined the process utilized to implement the compliance and efficacy monitoring of individuals with high or medium risks directly associated with PNM supports. Therapists were to complete efficacy monitoring for individuals with PNMPs on a quarterly basis. To begin this process, on 11/1/13, a PNM/Communication Effectiveness Monitoring Tool had been developed and therapists were implementing it for a few individuals on their caseload. At a later date after the Monitoring Team's onsite review, the therapists planned to evaluate, the effectiveness monitoring tool and make revisions, if necessary. At the time of the review, no instructions and/or guidelines had been developed for the effectiveness monitoring tool. The Facility should ensure that the effectiveness monitoring results address the effectiveness (i.e., is the individual better or worse?) of implemented PNM strategies, as well as the impact on identified risk indicators and/or safety concerns. The provision of objective clinical baseline data and measures/objectives in IRRFs and IHCPs will be	Noncompliance

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		necessary, because this will provide evidence to complete effectiveness monitoring for individuals with PNM difficulties and to revise interventions, as appropriate. None of the 15 (0%) individuals' records in Sample O.1, and none of five (0%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. One of the 15 (7%) (i.e., Individual #132) individuals' records in Sample O.1, and none of five (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. However, the PNM/Communication Program Effectiveness Monitoring form only addressed program implementation monitoring for mobility and lift/transfer for Individual #132. His PNMP/dining plan had strategies for mealtime, oral care, bathing, medication administration, positioning, and toileting. The outcome of effectiveness monitoring should be to ascertain if prescribed interventions have been effective in minimizing and/or eliminating identified PNM concerns, and in instances in which progress has not been made, interventions should be reviewed and modified, as appropriate. Simply put, is the individual better or worse? This question should be answered through a review and analysis of data that staff are collecting and measuring against goals in the ISP/IHCP. These goals should be based on objective clinical data (e.g., identification of an oxygen saturation threshold that an individual will maintain for an identified period of time). The objective clinical data that should be collected to support the individual's health/wellness should be identified in individual's IHCP goals and tracked by identified staff (e.g., nursing). Therapists should complete effectiveness monitoring by reviewing data in individual's records and direct observation, which might include a hands-on assessment. For none of the four (0%) individuals (i.e., Individual #235, Individual #245, Individual #132, and Individual #222) 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. Three individuals (i.e., Individual #245, Individual #235, and Individual #132) were identified as receiving direct therapy, but there was no direct therapy plan provided and/or monthly progress notes. Individual #222's Habilitation Therapy Plan purpose stated: "Individual #222 will participate in activities to improve his standing transfers and facilitate ambulation." His plan did not identify objective clinical data to assess the effectiveness of 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 could not be evaluated, but will be during	

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		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. Based on documentation submitted, the Facility did not use trigger sheets. As a result the following was not reviewed: ▪ ____ of ____ (%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. ▪ ____ of ____ (%) individuals' Trigger sheets included individualized triggers as indicated. ____ of ____ (%) individuals' Trigger sheets were completed correctly. ▪ ____ of ____ (%) individuals' Trigger sheets were reviewed by the RN on a daily basis. Individual-specific triggers were identified on PNMPs, IRRFs, and IHCPs. Based on interview with the Director of HT and review of IHCPs, direct support professionals were responsible for reporting to nursing if they observed an individual experiencing an identified trigger. However, no formalized process was described in Facility policies and/or procedures reviewed that required a different approach to tracking and/or trending incidences of individuals who experienced identified triggers. Individuals' IRRFs/IHCPs should further define how individual-specific triggers will be tracked and trended to monitor the progress of individuals with physical or nutritional management difficulties, and prompt revisions of interventions, as appropriate. In summary, the Facility had developed a protocol to define the system for effectiveness monitoring. An effectiveness monitoring tool had been developed and therapists were implementing it on a trial basis for a few individuals on their caseloads. The tool was to be re-evaluated after this trial and revisions would be made, if necessary. The Facility should develop instructions/guidelines for the effectiveness monitoring tool to support consistency and inter-rater agreement. Effectiveness monitoring should address all components of an individual's physical and nutritional support plan and/or any other indirect supports. 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	**<u>Assessment of Individuals Who Receive Enteral Nourishment</u>** The Facility HT Master List protocol, implemented on 9/30/13 and revised on 11/11/13, identified the Chief Clinical Dietician as the "enteral nourishment list keeper." The names of individuals who received enteral nourishment were maintained on an HT Enteral list. The information to maintain and update this list was obtained from medical providers' orders and hospital reports. The Facility had a sustainable system to maintain and update the list of individuals who received enteral nutrition.	Noncompliance

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	use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	A review was conducted of the six individuals in Sample O.3 (i.e., Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, and Individual #89). Six of six individuals (i.e., Individual #269, Individual #114, Individual #167, Individual #62, Individual #324, and Individual #89) (100%), who received enteral nutrition, were evaluated at a minimum annually. None of the six (0%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. The information necessary for such an assessment was supposed to be summarized on the IRRF, and the team discussion/deliberations regarding the necessity of the tube documented on the IRRF. Although the IRRF now contained space for this, the necessary information and/or team deliberations were not documented for the individuals in the sample. 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 analysis and safety of intake or development of an oral motor treatment plan, as appropriate. The four individuals (i.e., Individual #85, Individual #98, Individual #88, and Individual #91) admitted since the Monitoring Team's last review ate orally and did not receive enteral nourishment. The following was not applicable for review: ▪ ____ 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. **<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u>** None of the six (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	

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		of feedings to determine if there is a possibility for modification to the least restrictive schedule. Justification for/or against modification of formula/schedule should be included as part of assessment findings. Since the last review, the Facility Protocol for Return to Oral Eating and/or For Least Restrictive Intake, dated 1/8/14, had been developed. The protocol addressed the components of a comprehensive plan for individuals who were potential candidates to return to oral eating and/or for least restrictive intake. Based on interview with the HT Director, there were no individuals who as the time of the review and/or since the last review had a plan developed and implemented for a potential return to oral intake. As a result, the following metrics were not evaluated, but will be, as applicable, during upcoming reviews: ▪ ____ of the ____(%) individuals 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. The plan should include all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation and monitoring); o Time and schedule of interventions; o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (i.e., method for tracking progress); and o Frequency of subsequent assessments and staff responsible ▪ ____ 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 should 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	

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		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 it is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. In summary, the Facility had a sustainable system for identifying individuals who received enteral nourishment. A protocol had been developed and implemented to define this process. The Facility's Self-Assessment noted this provision was not in substantial compliance "due to not having an integrated assessment and/or discussions as well as documented plans for any modification of intake." This was consistent with the Monitoring Team's findings. Individuals in the sample who received enteral nutrition were reviewed by the IDT, but the discussion in the IRRF Aspiration section did not address the necessary components. The Facility had developed a protocol to define the process for the pathways for a return to oral eating and/or receiving enteral nourishment in the least restrictive manner. This protocol also identified what the therapist and/or dietician would discuss with IDT members upon completion of their respective assessments. The implementation of this protocol should assist the Facility in moving in the direction of reaching substantial compliance. 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 in Sample P.1 [i.e., individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s)]: Individual #165, Individual #190, Individual #233, Individual #135, Individual #114, Individual #167, Individual #62, Individual #53, Individual #73, Individual #235, Individual #51, Individual #14, Individual #132, Individual #245, and Individual #22, 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, and incident reports and Facility investigations for choking incidents; o For the following four individuals in Sample P.2 (i.e., Individual #235, Individual #245, Individual #132, and Individual #222) who were reported to receive direct OT and/or PT services, the following documents: 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 OT/PT assessments for the following four individuals who had been newly admitted: (i.e., Individual #85, Individual #98, Individual #88, and Individual #91); 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; o Physical Nutritional Management Maintenance Log; o OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; o Tracking Log of completed individual assessments; o Wheelchair seating and PNM clinic assessment (templates); o Compliance Monitoring form template; o Competency-based performance check-off sheet templates for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; o Summary reports and monitoring results related to OT/PT; and o List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interview with**: o Linda Thomas, Director of Habilitation Therapy. ▪ **Observations of**: o Individuals in residences, dining rooms, and day programs.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 12/20/13. 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. Based on a review of the Facility Self-Assessment and interviews with the Director of HT, the following was found: ▪ In September 2013, the Facility began tracking key indicators. The Administrative Outcome Measure document included data that had been collected for the months of September, October, and November 2013. The key indicators for Section P were: o Physical, Mental and Behavioral Health, and Well-Being ▪ Percentage of scheduled assessments for all clinical disciplines completed within the required time frame; ▪ Number of residents that have a current Integrated Health Care Plan; and ▪ Number of residents who have an integrated OT/PT assessment that considers significant health issues and risk indicators; o Preventative Care and Disease Management ▪ Number of persons with a PNMP; and o Access to Services ▪ Number of residents with an identified need for assistive equipment. The tracking and trending of QA/QI key indicators for Section P was a step in the right direction. However, additional work will need to be completed in the development of methodologies, standards, and criterion to support accurate reporting with these key

	indicators. For example, it was unclear how the Facility planned to measure the quality of "an integrated OT/PT assessment that considers significant health issues and risk indicators," and if a monitoring/audit tool was going to be used, who would be responsible, how they would be trained, etc. In addition, many of the indicators were merely demographic in nature (e.g., number of individuals with need for assistive equipment, with PNMPs, with IHCPs, etc.), and expansion of indicators will be necessary to measure both the quality of supports provided, and the outcomes achieved with individuals. ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tools (i.e., OT/PT assessment and PNMP audit tool). The Facility was not using the State Settlement Agreement Monitoring Tool for Section P. o The data presented in the Self-Assessment indicated that multiple audits were conducted, including review of OT/PT assessments for individuals newly admitted, review of ISPs for incorporation of OT/PT assessment recommendations, and reviews using the OT/PT assessment audit tool. o The Self-Assessment identified the sample sizes used to complete audits, including the information necessary to determine the percent sample in comparison with the overall population. o The Facility-based audit tools (i.e., OT/PT assessment audit tool and PNMP audit tool) did not have adequate instructions/guidelines including standards and criteria. o The following staff/positions were responsible for completing audits for the Settlement Agreement for Section P: the Director of HT and therapists. Currently, no Facility PCMs were responsible for completing the Self-Assessment. The Director of HT and therapists were working with a Facility PCM to provide training in compliance monitoring. In the future, if data is collected by a PCM, it should be identified in the Self-Assessment. o Adequate inter-rater reliability had not been established between the Director of HT, therapy staff, and the PCM. ▪ The data presented in the Self-Assessment reflected the completion of additional review activities, such as analysis of PNM foundational training databases for NEO, and review of annual refresher training for PNM foundational training, etc. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings consistently based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with the Sections P.1 and P.3. The Monitoring Team found the Facility was in substantial compliance with Section P.3, but not with Section P.1. Individuals' OT/PT assessments included 17 of 22 assessment elements. However, there were missing elements as discussed in further detail below. In addition, individuals who had experienced a change in status did not have assessment updates and/or consultation that included the necessary elements. The Facility rated itself as not being in compliance with Sections P.2 and P.4, which was consistent with the Monitoring Team's findings. ▪ The Facility's data identified areas in need of improvement, but did not provide specific information regarding the analysis of the information and/or the development of interventions to address finding that did not support compliance.

	Summary of Monitor's Assessment: The four individuals who were recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Individuals' OT/PT assessments included 17 of 22 assessment elements, however, essential elements continued to be missing. Individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements. Three of four individuals reviewed who were receiving direct OT and/or PT interventions did not have therapy plans. Monthly progress notes had not been consistently completed, and did not include the necessary elements. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs. Competency-based training for the implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with Section P.3. The Facility was in substantial compliance with Section O.5 and, therefore, Section P.3. The Facility had OT/PT policies/protocols that included the necessary elements. A protocol had been developed and implemented that described the system for monitoring individuals' assistive equipment. PNMP Coordinators were monitoring individuals' assistive equipment on a daily basis for availability (i.e., presence), cleanliness, condition, need for repairs, and need to replace (i.e., due to condition, not available). Direct support professionals also were responsible for monitoring individuals' assistive equipment daily for use and wear, and reporting to HT staff if any repair and/or replacement were needed. The Facility still had work to do to monitor the implementation and effectiveness of individuals' OT and PT supports.

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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	**Definition of Samples** ▪ **Sample P.1** consisted of the following 15 individuals: Individual #165, Individual #190, Individual #233, Individual #135, Individual #114, Individual #167, Individual #62, Individual #53, Individual #73, Individual #235, Individual #51, Individual #14, Individual #132, Individual #245, and Individual #22; and ▪ **Sample P.2** consisted of four of the seven individuals who received direct OT and/or PT services, including: Individual #235, Individual #245, Individual #132, and Individual #222. Two of these individuals (i.e., Individual #235 and Individual #132) also were included in Sample P.1. **Timeliness of Assessments** Four of four (100%) newly admitted individuals (i.e., Individual #85, Individual #98, Individual #88, and Individual #91) received an OT/PT assessment within 30 days of admission or readmission.	Noncompliance

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	and health risk indicators in a clinically justified manner.	Based on review of 15 assessments for individuals in Sample P.1: ▪ Fifteen of 15 individuals' OT/PT comprehensive assessments or assessments of current status (100%) were dated as having been completed at least 10 days prior to the annual ISP. ▪ Fifteen of 15 (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **<u>OT/PT Assessment</u>** Based on review of 11 assessments for individuals in Sample P.1 (i.e., Individual #53, Individual #62, Individual #190, Individual #167, Individual #14, Individual #233, Individual #165, Individual #114, Individual #73, Individual #51, and Individual #135), and four individuals in Sample P.2 (i.e., Individual #235, Individual #132, Individual #222, and Individual #245) the comprehensiveness of the OT/PT assessments was as follows: ▪ Fifteen of 15 (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Fifteen of 15 (100%) assessments included medical diagnoses. ▪ Fifteen of 15 (100%) assessments included medical history. ▪ Fifteen of 15 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. ▪ Fifteen of 15 (100%) assessments addressed health status over the last year. ▪ Fifteen of 15 assessments (100%) included a comparative analysis that clearly analyzed the individuals' level of health status with previous years or assessments. ▪ Fifteen of 15 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. ▪ None of 15 (0%) assessments listed medications and potential side effects relevant to functional status. More specifically: o Thirteen assessments (i.e., Individual #165, Individual #62, Individual #53, Individual #245, Individual #235, Individual #135, Individual #73, Individual #114, Individual #233, Individual #167, Individual #190, Individual #132, and Individual #51) listed the individual's prescribed medications. However, these assessments did not list the potential side effects of these medications. o Two assessments identified the side effects of medications (i.e., Individual #14 and Individual #222), but the generic statement included did not specifically define the potential impact on their functional status and/or the individual-specific HT supports. o Although some went beyond the generic statement (i.e., Individual #62, Individual #165, Individual #245, and Individual #53), they did not	

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		include all of the necessary information. For example, Individual #53's assessment stated "[Individual #53] is prescribed medications with side effects which may be pertinent to Habilitation Therapy including nausea, back pain and body weakness from her Fenofibrate which may affect [Individual #53's] ability to participate in mobility, transfers, or movements." However, no medication side effects were listed for her many other medications. ▪ Fifteen of 15 (100%) individuals' OT/PT assessments included individual preferences, strengths, and needs. ▪ Fifteen of 15 (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Fifteen of 15 (100%) 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. ▪ Six individuals required a wheelchair as a primary mobility device (i.e., Individual #132, Individual #53, Individual #62, Individual #167, Individual #14, and Individual #114). Six of six assessments (100%) provided 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. Nine individuals (i.e., Individual #235, Individual #222, Individual #245, Individual #190, Individual #233, Individual #165, Individual #73, Individual #51, and Individual #135) did not use wheelchairs for their primary mobility. ▪ None of 10 assessments (0%) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. Specifically, the OT/PT assessments did not report the results of PNMP compliance monitoring and/or effectiveness monitoring. ▪ Fifteen of 15 assessments (100%) included recommendations for services and supports. ▪ Eight of 15 (53%) (i.e., Individual #235, Individual #132, Individual #222, Individual #245, Individual #53, Individual #62, Individual #14, and Individual #135) assessments included a comparative analysis of current functional motor and activities of daily living skills with previous assessments. ▪ Fifteen of 15 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP/dining plan that addressed the individuals' PNM risk levels; ▪ Eleven of 15 (73%) assessments (i.e., Individual #132, Individual #222, Individual #245, Individual #53, Individual #62, Individual #190, Individual #14, Individual #233, Individual #165, Individual #51, and Individual #135) included discussion of the individual's potential to develop new functional	

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		skills. ▪ Fifteen of 15 (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. ▪ Fifteen of 15 (100%) assessments included a monitoring schedule. The assessments indicated that direct support professionals were to monitor individuals' assistive equipment on a daily basis. PNMP Coordinators were also responsible for reviewing the status of individuals' equipment. In addition, per policy individuals with high PNM risks were to be monitored monthly and individuals with medium risks were to be monitored quarterly. ▪ Fifteen of 15 (100%) assessments included a reassessment schedule. ▪ Fifteen of 15 (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. ▪ Fifteen of 15 (100%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The 15 OT/PT assessments reviewed all had 17 of 22 assessment elements present. The following elements were not present in some of the assessments: ▪ Medications' potential side effects relevant to functional status; ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; ▪ Comparative analysis of current functional motor and/or activities of daily living skills with previous assessments; and ▪ Discussion of the individual's potential to develop new functional skills. The following four individuals in the samples had experienced a change in status since the last review: Individual #165 (i.e., weight loss), Individual #233 (hospitalization from 10/16/13 to 10/23/13 with a diagnosis of pneumonia), Individual #269 (hospitalization from 8/23/13 to 8/26/13 with a aspiration pneumonia), and Individual #114 (hospitalization 8/25/13 to 8/30/13 with a diagnosis of pneumonia): ▪ For none of four (0%) individuals, did updates provide 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. Individual #114 had a consultation completed, but the consultation did not include the	

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		effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year as well as monitoring data. For the remaining three individuals, no updates/consultations had been completed. In summary, the four individuals who were recently admitted to the Facility had OT/PT assessments completed within 30 days of admission. Individuals' OT/PT assessments included 17 of 22 assessment elements. Individuals who had experienced a change in status either did not have assessment updates and/or consultations completed, or those that were completed did not include the necessary elements. The Facility remained out of compliance with this subsection.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Direct OT/PT Interventions** Seven individuals received direct OT and/or PT services. Sample P.2 was comprised of four of these seven individuals (i.e., Individual #235, Individual #245, Individual #132, and Individual #222). The Monitoring Team requested documentation that would document the provision of direct therapy. However, no therapy plans and/or supporting documentation were submitted for three individuals in the sample (i.e., Individual #235, Individual #245, and Individual #132). ▪ For revisions in direct intervention plans made since the last visit, one of four (0%) individuals' direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. The Monitoring Team was not able to discern if direct intervention plans had been implemented for three of the individuals, because plans were not submitted. Individual #22's HT consultation, dated 8/2/13, recommended the initiation of active treatment to work on "gait, transfers and mobility while wearing prescribed walking boot." His therapy plan was implemented on 8/6/13. ▪ For one of four (25%) (i.e., Individual #222) individuals' records reviewed, the current OT/PT assessment and/or consultation identified the need for direct intervention with rationale. ▪ For none of four (0%) individuals' records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. The purpose of Individual #222's direct intervention plan stated: "[Individual #222] will participate in activities to improve his standing transfers and facilitate ambulation." However, there were no measurable objectives that required the collection of data to ascertain when Individual #222 had achieved the stated purpose of his direct therapy. ▪ For none of three individuals' records whose therapies had been terminated (0%), termination of the intervention was well justified and clearly documented in a timely manner. Individual #235, Individual #245, and	Noncompliance

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		Individual #132 were reported to have received direct OT and/or PT interventions. None of these three individuals had an HT Activity Plan, and there were no monthly progress notes to document their discharge from therapy. 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** A review of the sample of 11 assessments and ISPs/ISPAs for individuals in Sample P.1 (i.e., Individual #53, Individual #62, Individual #190, Individual #167, Individual #14, Individual #233, Individual #165, Individual #114, Individual #73, Individual #51, and Individual #135), and four individuals in Sample P.2 (i.e., Individual #235, Individual #132, Individual #222, and Individual #245) found the following: ▪ For 12 of 15 individuals' ISPs (80%) (i.e., Individual #235, Individual #132, Individual #222, Individual #245, Individual #53, Individual #62, Individual #190, Individual #14, Individual #233, Individual #165, Individual #114, and Individual #73), an OT or PT attended the ISP or ISPA meeting, if the individual was receiving any direct or indirect OT/PT service, or adequate justification was provided. ▪ For individuals receiving OT/PT supports and services, 11 of 15 plans (73%) (i.e., Individual #53, Individual #62, Individual #190, Individual #167, Individual #14, Individual #233, Individual #165, Individual #114, Individual #73, Individual #51, and Individual #135) were developed within 30 days of the date of the ISP, or an ISPA meeting following the assessment/update, or sooner as indicated by need. ▪ For none of 15 individuals, (0%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment. ▪ In none of 15 (0%) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. ▪ For none of 15 individuals (0%), the ISP/ISPAs contained measurable objectives related to interventions. Generally accepted practice standards for comprehensive progress notes related to PT/OT interventions include that they:	

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		▪ Contain information regarding whether the individual showed progress with the stated goal, including summary of clinical data and other documentation 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 ▪ Are completed on at least a monthly basis. Based on the Monitoring Team's review: ▪ None of four (0%) individuals (i.e., Individual #235, Individual #245, Individual #132, and Individual #222) receiving direct OT/PT services was provided with comprehensive progress notes at least monthly that contained each of the indicators listed above. Individual #222's direct therapy plan's method of review indicated the therapist would complete monthly progress notes and the QIDP would complete a monthly review. Daily Progress Notes were submitted, however, there were no monthly progress notes provided, including a summary and analysis of the data for the month. ▪ For individuals who received indirect OT and/or PT programs (e.g., PNMPs or SAPs), monthly documentation from the OT and PT and/or QIDP was present for none of the 15 individuals (0%), including the following: o 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); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. In summary, three of four individuals receiving direct OT and/or PT interventions did not have therapy plans. Monthly progress notes had not been consistently completed and did not have the necessary elements. OT/PT assessment recommendations and/or recommendations for SAPs had not been integrated into individuals' ISPs. The Facility remained out of compliance with this subsection.	
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	**<u>Competency-Based Training</u>** Competency-based training for direct support professionals related to implementation of PNMPs is addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with this section. The Facility was in substantial compliance with Section O.5, and, therefore, Section P.3.	Substantial Compliance

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	the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.		
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Monitoring System** Monitoring of PNMPs is discussed in detail with regard to Section O.6. Substantial compliance with Section O.6 is the standard for compliance with this section. The Facility was not in substantial compliance with Section O.6. The Facility submitted the following policies and/or procedures: ▪ LBSSLC – IDT – Program Development Occupational Therapy and Physical Therapy Services, revised 10/28/13; ▪ LBSSLC Protocol for Individual-Specific Competency-Based Training PNM and Communication Skills, dated 11/11/13; ▪ Protocol to Identify Individuals Who Require Individual-Specific Competency-Based training and are High Risk for Aspiration Pneumonia and/or choking, dated 11/12/13; ▪ LBSSLC Protocol for Process of Maintaining Master Lists, dated 8/30/13; ▪ LBSSLC Protocol for Dental Department, dated 11/6/13; and ▪ LBSSLC Protocol for Checking/Monitoring of Assistive Devices Individual Equipment, dated 1/8/14. The Protocol for Checking/Monitoring of Assistive Devices Individual Equipment, dated 1/8/14, stated PNMP Coordinators were responsible to check/monitor individual's equipment daily for the homes they were assigned. Assistive equipment was monitored for availability (i.e., presence), cleanliness, condition, need for repairs, and need to replace (i.e., due to condition, not available). Missing and/or damaged equipment was to be replaced the same day, and in no more than 30 days unless equipment required ordering and/or other extenuating circumstances. The protocol also indicated where and how the PNMP Coordinator and/or any other HT staff would document the equipment replacement process. More specifically, an "Equipment Log" document (i.e., signature of staff replacing/securing the equipment, what equipment is needed and why, date requested, date replaced, and/individual and/or home) was maintained in the HT equipment room. The Equipment Log was initiated on 10/1/13. The Facility submitted Equipment Logs that provided documentation of equipment that was needed and secured with a date range from 10/2/13 to 1/8/14. One hundred and three (103) different types of assistive equipment were replaced for multiple individuals. Replacements of equipment typically occurred on the same day as PNMP Coordinators, other HT staff, and/or direct support professionals, requested the equipment. None of these replacements exceeded 30 days.	Noncompliance

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		When equipment needed to be ordered or there were other extenuating circumstances, the PNMP Coordinator and/or any other HT staff would document (i.e., signature of staff, what is needed, who was notified, date when replaced, and/or action take to resolve issues) in the "Needed Log." Based on interview, the Director of HT stated direct support professionals also were responsible for monitoring individuals' assistive equipment daily for use and wear, and for reporting to HT staff if any repair and/or replacement were needed. The Facility did have a comprehensive OT/PT policy or set of policies and procedures that included the following elements: ▪ Description of the role and responsibilities of OT/PT; ▪ 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; ▪ 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 for individuals receiving direct services. For 15 of 15 (100%) individuals, routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Routine maintenance meant that therapists or designated staff reviewed equipment at least monthly. As stated above, PNMP Coordinators and direct support professionals were monitoring individuals' assistive equipment on a daily basis. Eleven of 11 individuals for whom adaptive equipment was noted to be in disrepair or needing replacement (100%) (i.e., Individual #53, Individual #62, Individual #324, Individual #132, Individual #73, Individual #114, Individual #165, Individual #233,	

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		Individual #14, Individual #167, and Individual #190) 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. The four remaining individuals' assistive equipment (i.e., Individual #235, Individual #51, Individual #269, and Individual #135) did not require repairs and/or replacement. In summary, the Facility had OT/PT policies/protocols that included the necessary elements presented in this subsection. A protocol had been developed and implemented that described the system for monitoring individuals' assistive equipment. Individuals' assistive equipment was being monitored on a daily basis by PNMP Coordinators for availability (i.e., presence), cleanliness, condition, need for repairs, and need to replace (i.e., due to condition, not available). Direct support professionals also were responsible for monitoring individuals' assistive equipment daily for use and wear, and reporting to HT staff if any repair and/or replacement were needed. Based on a review of a sample of individuals, replacements and repairs were occurring promptly. Monitoring of the implementation of PNMPs is discussed in detail with regard to Section O.6. Substantial compliance with Section O.6 is one of the standards for compliance with this section. The Facility was not in substantial compliance with Section O.6.	

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 updated policies/ procedures/protocols, with 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 office's record of visit and copy form active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record); o Five most recent offsite oral surgery consults and progress notes past six months; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for

	appointment (i.e., prophylaxis, annual, etc.), name, date of refusal and date of completion; o List of those who have not seen dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill requirement/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last onsite visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months (including reason for appointment, 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, residential 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, IPN 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 office for: Individual #116, Individual #67, Individual #182, Individual #232, and Individual #4; 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 (i.e., medical, anesthesia clearance, etc.), and post-operative checklist or monitoring forms, IPN on date of procedure, etc., for: Individual #33, Individual #217, Individual #213, Individual #65, and Individual #251; o For the past six months, copies of any correspondence concerning restraint and sedation use at time of office visit (i.e., to QDDP, team, psychologist, etc.); o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the dental department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach 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 extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #238, Individual #4, and Individual #116; 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: Individual #274, Individual #46, Individual #26, Individual #1, Individual #65, Individual #90, Individual #264, Individual #170, Individual #306, and Individual #174; 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; o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #99, Individual #26, Individual #38, Individual #174, Individual #60, Individual #116, Individual #272, Individual #75, Individual #184, and Individual #23; o The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, 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 submitted information included 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 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 (Electronic copy 2013 and hard copy 2011); o General anesthesia policy, 12/13/13 (R); o Oral care policy, 12/13/13 (R); o Dental Services policy, 12/13/13 (R); o Dental scheduling process; o Oral hygiene training process; o Skill Acquisition Plan (SAP) process document; o Data for all dental desensitization/SAP programs, recent months; o Completed periodontal charting for past year; o Positive monitoring steps of dental QA past six months; and o Number of restorations per individual past six months. ▪ **Interviews with**: o Russell Reddell, DDS, MBA, 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, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Section Q Monitoring Tool. 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 Nurse. o Inter-rater reliability was not possible, because only the QA Nurse completed monitoring. There were no dental staff members completing monitoring. ▪ The Facility did not use to the extent necessary other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the Dental Department's databases was noted to be incomplete and inaccurate at times, and the amount of detail provided

	might have been insufficient to allow determinations to be made regarding quality of care, especially if the database relied on the dental template for the annual dental assessments. There were numerous statistics available on measurable indicators. However, examples of databases/data sources that were not considered in the Facility's Self-Assessment included information regarding the completeness and quality of dental plans, tracking the rate of extractions or tooth loss (i.e., for non-traumatic reasons and excluding impacted wisdom teeth), tracking the rate of new caries per quarter, the numbers of individuals with severe periodontitis, the number of permanent fillings needing restoration/replacement within a 12 to 24 month time interval, tracking periodontal charting/probing in those with periodontitis, and tracking to ensure success for all individuals with dental desensitization programs or behavior programs that currently needed restraints or general anesthesia/TIVA for cooperation. Although the Facility presented some summary data of the current status of a number of measurable indicators from the dental database, this was a snapshot of information, which provided a current status of dental services. It did not provide any information as to whether these numbers had improved or worsened from prior quarters and years. As a result, the Facility did not present trend data in a meaningful/useful way. Specifically, the Facility's Self-Assessment appeared to rely on raw data. There were few graphs or charts demonstrating trends. ▪ The Facility did present findings consistently based on specific, measurable indicators. However, the Dental Department did not provide summaries of monitoring/auditing data in charts. In the Self-Assessment, there was limited, if any, analysis for any trends. Only the QA Department provided trend analysis information. However, trend analysis with graphs or charts (i.e., oral cancer screening, etc.) was not submitted. ▪ The Facility did not consistently measure the quality as well as presence of items. Treatment plans and the depth of information provided at the annual dental assessments were examples of areas that lacked measurement of quality. ▪ The Facility rated itself as being in noncompliance with Sections Q.1 and Q.2. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified some areas of in need of improvement, such as the lack of timely completion of annual assessments for the ISP process.
	Summary of Monitor's Assessment: The Dental Department continued to have significant challenges. A number of annual dental assessments remained overdue. Additionally, the quality of the dental assessments required further monitoring in such areas as adequate treatment plans and adequate descriptions of the behaviors of the individuals. For those individuals with significant dental disease, who also had severe, comorbid medical conditions, an arrangement was made to have dental care provided at a local area hospital. This increased monitoring and additional expertise available had proved successful in treating these individuals with medical complexities that were at high risk for complications during dental procedures/general anesthesia. Tracking periodontal disease did not appear to be a priority of the Dental Department. Even for those undergoing general anesthesia, completion of a periodontal chart or periodontal probe results were often lacking.

	From the information the Facility provided, the majority of individuals (75%) were to undergo general anesthesia routinely for preventive cleaning, because, according to the Dental Department, the severity of periodontal disease required general anesthesia for cleaning to occur. From the review of a sample of individuals undergoing general anesthesia, there was no plan in place to reduce the severity of periodontitis in those who had a cleaning under general anesthesia, but plans were in place for continued periodic cleaning under general anesthesia. There was no mention of a SAP or other dental desensitization or behavior plan to improve cooperation. Preventive care strategies in place should be included in the treatment plan. If a SAP is in place, the SAP should be identified in the plan, as well as whether the SAP data indicated progress or needed revision at the time of the annual assessment. The plans should include steps being taken to prevent/reduce periodontitis and prevent tooth loss. If a SAP is needed, but has not been developed, a recommendation for one should be included in the plan to provide guidance to the IDT. The lack of programming to improve compliance in tooth brushing, oral hygiene exams, and cleaning indicated a failure to provide basic preventative dental care and services to this population. In this population, prevention likely would have the most impact on dental health. There were only a few individuals for whom a desensitization program or other strategies to reduce the need for sedation were in effect. All individuals with moderate to severe periodontitis should have had a desensitization/behavioral program with continuous monitoring, service objectives for staff to assist with brushing their teeth, and/or a plan for the Dental Department to teach staff and individuals better tooth brushing skills, with training occurring both in the residence and in the dental chair. For some requested documents for Section Q, there were continued problems. The hard copy of the Presentation Book was not the current copy, but was dated 2011. The request for similar documents from both the dental office record and the active record remained problematic, even though this was discussed in the Monitoring Team's prior report. If requested information is not provided, the Monitoring Team is unable to conduct the review necessary to confirm compliance. The Facility remained in noncompliance with Sections Q.1 and Q.2.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care	<u>Staffing</u> One full-time dentist, one part-time dentist, two dental assistants, and one registered dental hygienist staffed the Dental Department. CPR certification was submitted for the Dental Department staff. Documentation was submitted verifying the full-time dentist, part-time dentist, registered dental hygienist, and registered dental assistant were current in CPR. One additional dental staff member had limited contact with individuals and was not required to be CPR certified. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for	Noncompliance

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	guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	the time period from June 1, 2013 through December 17, 2013 in a document entitled "Lubbock State Supported Living Center: Annual exams completed and previous." 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 84 individuals. None of these had database errors/typographical errors. There were three individuals listed that had no prior annual assessments, because they were new admissions. Of the remaining 81 individuals, 81 were listed with a prior annual examination date. Of these 81, 67 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 83 percent. There were 14 overdue annual examinations. The Dental Department documented that there were no individuals residing at LBSSLC who had not seen a dentist in the prior 365-day time period. Separately, copies of 10 annual dental assessments that were completed in the 30 days prior to the Monitoring Team 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. The content of the annual dental assessments included the following components: ▪ Nine of the 10 (90%) submitted assessments had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Nine of the 10 (90%) submitted assessments had entries for oral hygiene rating. For one, information was subsequently found in a Dental Progress Note (DPN), but was not documented on the "Dental Record Annual Examination" form. ▪ Ten of the 10 (100%) submitted assessments for individuals with teeth had entries for periodontal condition (i.e., type). ▪ Zero were edentulous. ▪ Zero of the 10 (0%) submitted assessments had entries indicating oral cancer screening. Oral cancer screening was addressed in a separate stamped DPN template. ▪ Ten of 10 (100%) submitted assessments indicated completion of an intra-oral exam and extra oral exam screening/soft tissue exam. If the extra-oral and intra-oral exams included oral cancer screening, it was not indicated. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in zero of 10 (0%) records. ▪ Ten of the 10 (100%) submitted assessments documented a summary of findings concerning presence of dental caries. ▪ Zero of the 10 (0%) submitted assessments provided information concerning treatment during the annual visit. This information was found in a DPN for 10 of 10 (100%) individuals. ▪ Ten of the 10 (100%) submitted assessments included a dental treatment plan. However, it appeared to provide little information, because it was generally	

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		documented as single words. Given the high rate of periodontitis, there was a need to provide more aggressive treatment. Nine of these 10 individuals underwent TIVA, but the subsequent plan was to repeat the dental visit at intervals under TIVA, or the next visit section was left blank. The opportunity to provide an aggressive treatment plan to reduce periodontitis was lacking in all cases. It was noted that most did not receive any dental procedure other than examination or teeth cleaning, yet nine underwent general anesthesia. This would not appear to be consistent with the expectations that desensitization programs or other strategies be put in place at LBSSLC to reduce or eliminate the need for anesthesia or sedatives to the extent possible. According to an interview with the Dental Director, the degree of periodontitis was so severe as to require anesthesia for tooth cleaning for large numbers of individuals at the Facility. But once individuals' teeth were cleaned using the most restrictive form of sedation (i.e., general anesthesia), there was no plan to maintain an improved periodontal state. If that were to occur, the number of individuals needing general anesthesia for basic dental care should be reduced. However, zero of 10 dental plans included desensitization or other behavior plans to improve cooperation with oral hygiene procedures or dental care. ▪ Zero of the 10 (0%) submitted assessments documented oral hygiene recommendations. ▪ Zero of the 10 (0%) submitted assessments documented risk rating. ▪ Zero of the 10 (0%) submitted assessments documented community transition preparedness. A copy of 10 annual dental summaries (i.e., report submitted to the IDT for the ISP process) that had been completed in the prior 30 days to the Monitoring Team's visit were submitted for review along with the prior year's completed assessments. The content of this submitted document (i.e., annual dental summary) included the following components: ▪ Ten of the 10 (100%) submitted summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. However, for two individuals, there was conflicting information in the same document. The document template included one area that documented the rating of behaviors at the three most recent visits. In another area of the document, the current behavior status, based on the most recent appointment, was documented. This information did not agree for two dental summaries. The explanation for the discrepancy was not provided. Further, there was little information as to the behaviors of the individual when there was a fair or poor rating, which would guide the team to consider interventions to improve cooperation. Simply providing a one word description of behavior would be	

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		sufficient internal to the Dental Department, because the dental staff would have knowledge of the individual's behaviors in the dental chair, but it would not provide guidance to the IDT, nor would it help the community transition team and community dentist. There was also no key to determine what a "poor" behavior included, versus a "fair" behavior. Although the categorization of behavior was recorded in 10 of 10, zero of 10 (0%) provided sufficient applicable information for a transition to a community dentist, or as guidance to the IDT concerning steps needed to improve cooperation, or as information that would be helpful to the Behavioral Health Services Department in developing a desensitization program (i.e., did the individual exhibit biting, kicking, rocking, teeth clenching, jumping from the chair, fear of going through the doorway, fear of strangers, etc.). ▪ Ten of the 10 (100%) submitted summaries had entries for oral hygiene rating. ▪ Ten of the 10 (100%) submitted summaries had odontograms showing current restorations, missing teeth, etc. ▪ Ten of the 10 (100%) submitted summaries provided the periodontal type. ▪ Zero individuals were edentulous. ▪ Zero of the 10 (0%) submitted summaries had entries for oral cancer screening. This was documented on a separate stamped template in the IPN/DPN, but the reason for not including it in the dental summary was not determined. ▪ A periodontal chart or periodontal screening/probe record was completed/documented in zero of 10 (0%) records. The Dental Director indicated that individuals under general anesthesia would be candidates for periodontal probing as it may be uncomfortable without sedation for those with periodontitis, but the sample provided did not include the results of any periodontal probing. A subsequent request was made for the periodontal chart results for 10 individuals (as there had been 64 appointments using TIVA in the prior six months). The Dental Department was unable to find 10 individuals with periodontal charting/probe record, but was able to find eight. It would appear that the Dental Department was not tracking periodontal disease to determine whether interventions, such as tooth-brushing SAPs, flossing SAPs, desensitization, etc., were having a positive impact on oral hygiene and the reduction of periodontal disease. There was not a good baseline developed to determine any impact of interventions. Although the Dental Director indicated that periodontal probing caused discomfort, completion of this measurement while individuals were under TIVA was infrequently completed. ▪ Ten of the 10 (100%) submitted summaries documented a summary of findings/treatment during the annual visit. Findings were indicated on the odontogram with a color-coded key. Restorative care was indicated, but prophylactic care did not appear to be recorded on the dental annual summary. ▪ Although the summary comments might have indicated a change in oral hygiene	

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		scores over time as a narrative, there was no table or other format that listed dates and prior oral hygiene scores. Not all summaries included prior oral hygiene scores. ▪ Zero of the 10 (0%) submitted summaries included a dental treatment plan. From these summaries, there was little guidance given to the IDT as to the next step in dental care. There were some odontograms indicating need for further intervention, but the Dental Department identified no next steps. ▪ Ten of the 10 (100%) submitted summaries documented oral hygiene recommendations. However, there was little practical guidance given to the IDT. For example, seven individuals were identified as needing daily flossing, but there was no discussion as to how this was to occur and/or the role of the Dental Department. ▪ Of the 10 submitted documents, one individual had restorative care. From the information in the documents, all underwent general anesthesia. This was for a general annual exam and preventive care. This would normally not indicate the need for general anesthesia, but due to the severe periodontal disease, deep scaling and root planing was required, which was too painful without general anesthesia. Some of the individuals were listed as having good behavior during dental visits. There was no further guidance on creating desensitization plans that would be appropriately based in the dental office (i.e., frequent dental hygienist exams and treatments), and SAPs for tooth brushing and/or flossing. The Dental Department did not appear to consider the goal of reducing periodontitis, and hence, reducing the need for yearly or twice yearly general anesthesia. ▪ Nine of the 10 (90%) submitted summaries documented risk rating. ▪ Ten of the 10 (100%) submitted summaries documented community transition recommendations. However, six of the 10 included contradictory or confusing information. Five of the 10 included a statement "can be served in a less restrictive setting at this time, and I do not recommend that the individual be referred for community transition." It was unclear how this statement would guide the IDT. One of 10 had an incomplete statement "and I do/do not recommend that the individual be referred for community transition." Lack of review of the documents prior to distribution to the IDT appeared to occur. ▪ Completion of the annual dental summary occurred from less than one day to 76 days following the annual dental assessment. A number of pieces of information were lacking on the annual dental assessment form, which were found in other documents. The reason for not having all information in one source document was not determined. However, if all documents were not available, then the reader would not have a complete understanding of the dental condition of the individual. A consolidation of this information into one document might be helpful to the	

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		IDT and other departments. Additionally, the following were differences in content between the annual assessments and the annual summaries: ▪ The following information was recorded in the annual dental assessment, but not recorded in the annual dental summary provided to the IDT: dental treatment plan; ▪ The following information was recorded in the annual dental summary, but not included in the annual dental assessment: oral hygiene recommendations, risk rating, and community transition recommendation; and ▪ Neither included oral cancer screening, which was located in a separate DPN/IPN, and neither included positioning needs as identified by habilitation services. <u>New admissions</u> During the time period from June 1, 2013 through December 16, 2013, there were four new admissions. Four of four had an initial dental exam completed in the first 30 days (from eight to 29 days). <u>Oral Hygiene</u> An oral hygiene index was completed on each individual (that had teeth) at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire campus, in a document entitled: *Facility Oral Hygiene Data November 15, 2012 through November 15, 2013."* According to this document, for a census of 204 individuals, there were 15 individuals that were edentulous, and 189 individuals with teeth. Of the 189 individuals, seven categories of oral hygiene ratings were used. Zero of the individuals had an excellent oral hygiene score or a good to excellent oral hygiene score. Forty-one of 189 (22%) individuals with teeth had a good oral hygiene score. Ten of 189 (5%) individuals had a fair to good oral hygiene score. One hundred eight of 189 (57%) individuals had a fair oral hygiene score. Four of 189 (2%) individuals had a poor to fair oral hygiene score, and 26 of 189 (14%) individuals had a poor oral hygiene score. The Dental Department provided a brief narrative summary of the oral hygiene scores on a monthly basis. In this document, the goal was established that 85 percent of the individuals would score fair or above. References used in establishing this goal were not provided. This could be interpreted as a fairly low and unambitious goal, particularly for a population for whom staffing supports and dental services were available. The calculations did not remove individuals with repeat appointments during the month, which would skew the results as the oral hygiene scores were averaged for each month. It is recommended that for those individuals having more than one appointment in a month, only the most recent documented score be entered when averaging this information. Reports were submitted for June 2013 to November 2013. From the narratives, it appeared that annual exams occurred in specific residences each month.	

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		The oral hygiene scores often reflected the oral hygiene of the residence. Those with average or below average scores were to be considered for oral hygiene training in the residences as a focused approach to dental care. <u>Oral Hygiene Training</u> This area was reviewed to determine the following training categories: ▪ New employee oral hygiene training; ▪ Refresher course annual oral hygiene training; ▪ Chair side/office training of individuals/staff; ▪ Residential training of individuals/staff; and ▪ Technical assistance/training/monitoring of tooth-brushing SAPs, flossing SAPs, and desensitization programs. A document was submitted entitled: "Oral Care on iLearn" from 5/15/13 to 11/15/13. This was interpreted as a list of new employees trained in oral care. The list totaled 360 employees. A document was submitted entitled: "Active Employee Course Participation Report, 5/15/13-11/15/13 for the topic 'Oral Care – Dental Care.'" The Monitoring Team member clarified with a State Office personnel that this was a refresher course. Ninety-three staff were listed. Chair-side/office training was provided during preventive care visits and was documented in the DPN. Also included was a determination of whether the individual or staff were trained. Data was provided from 6/1/13 to 12/16/13. During this time there was documentation of toothbrush instruction at 139 individual preventive care visits. In the future, it is recommended that this be broken down by month, as well as separating individual instruction data from staff instruction data. These were the three documents submitted for training. Additionally, there was a roster for suction tooth brushing for four staff (later discussed in this section). There was no information that there had been in-service training in any residential setting for individuals with poor oral hygiene or the staff assisting these individuals. There was no information concerning technical assistance, training, or monitoring of direct support professionals in completing tooth brushing SAPs, flossing SAPs, or desensitization programs. The 10/15/13 QA/QI Quarterly Section Review for Section Q indicated that there was an ongoing tooth-brushing program. The Dental Hygienist and Dental Assistant had started residential visits for those residences needing further guidance/training in tooth brushing. There was no data provided indicating the number of individuals or staff	

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		trained per week or per month. There was mention of improved oral hygiene scores due to the impact of the tooth-brushing program, but no information was provided as evidence of this statement. Additionally, the Dental Department had met with IDT and residential staff in determining reinforcers that had been approved for the individual. The Dental Department then ordered them, and they were to be used to motivate individuals to complete dental appointments, and comply with tooth brushing and/or flossing SAPs. From an undated document: "Homes with Reinforcer Programs/Closets," 12 residences were listed in which reinforce programs were utilized. Examples of edible reinforcers were submitted for seven individuals. This appeared to be a new program for the Dental Department. There appeared to be no information as to whether the reinforcer program had improved compliance rates of appointment attendance, tooth brushing, etc. There was no information provided that a mechanism to collect data had been developed for this program. <u>Suction Tooth-brushing</u> As part of preventive oral care, suction tooth brushing was provided to those with one or more of the following indications for this procedure: history or risk of aspiration pneumonia, or enteral feeding with history or risk of aspiration pneumonia. Each individual had one or more of the indicated reasons. A list submitted documented 53 individuals received suction tooth brushing, which was 53 out of 202 (26%) of the population. From a document entitled: "Individuals with Suction toothbrush," dated 11/6/13, and updated 12/5/13, 26 additional individuals were identified as qualifying for suction tooth brushing, but were not receiving that hygienic procedure. Reasons identified for needing suction tooth brushing for these individuals included a history of aspiration pneumonia, poor oral hygiene, and enteral feeding with aspiration pneumonia. The QA/QI Quarterly Section Review for Section Q meeting minutes, dated 7/30/13 and 10/15/13, both discussed expansion of the use of suction tooth brushing. However, it appeared during this interval that little progress had been made. As noted in the 11/6/13 document, updated 12/5/13, this was still a project that had not expanded. Email correspondence had confirmed that the "first order of 32 suction machines" had been ordered as of 10/23/13. Additionally, direct support professionals were to be selected by the Residential Coordinator for training in suction tooth brushing. There was no further update whether the selection process and training had occurred. In a separate submitted document: "Attendance Roster: Suction Toothbrush Training for 12/17/13," four staff signatures were listed without titles. It was not clear if these four were among the direct support professionals chosen for the suction tooth-brushing program, if this	

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		was a refresher course, or whether Nursing Department staff were being trained. Sufficient information should be provided on the training documents for accurate interpretation. <u>Individuals with self brushing plans</u> From a document entitled: "Individuals that Brush, Hygiene scores," dated 12/9/13, 27 individuals were listed that brushed their own teeth. The oral hygiene scores of 26 of these 27 individuals were submitted for the prior two ratings completed at the time of the annual exam. For one individual, only one rating score was listed. ▪ Eighteen remained in the same category of oral hygiene rating. o There were no individuals with good oral hygiene scores that maintained a good oral hygiene rating. o For 17 individuals, a fair oral hygiene rating was maintained. o One individual maintained a poor oral hygiene rating. For this one individual, 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 six 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 one individual the rating improved from fair to good. o For zero individuals, the rating improved from poor to good. ▪ For two individuals, the oral hygiene ratings worsened o For zero individuals, the rating changed from good to poor. o For one individual, the rating changed from good to fair. o For one individual, the rating 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> A document entitled: "Individuals that floss," dated 12/9/13, listed 15 individuals that flossed their own teeth. Information as to whether or not the flossing required assistance or observation was not submitted. 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 assistance. From a document entitled: "Individuals That Brush But Do Not Floss and Reason," dated 12/6/13, 25 individuals were listed that were unable to floss, but were able to brush their own teeth. Reasons provided included: lack of dexterity (24), and pica (one).	

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In the prior six months, there was training of individuals in flossing their own teeth. A document entitled: "Individuals that on their [sic]," scanned 12/9/13, documented that 42 individuals were provided instruction for flossing. Eighteen individuals were able to floss. Dates of flossing instruction were from 5/9/13 to 12/3/13.

Pneumonia

The Facility submitted a list of those with a diagnosis of pneumonia from May 1, 2013 through November 15, 2013, 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 pneumonia, zero individuals had dental appointments within the eight days prior to the date of the pneumonia diagnosis.

Preventive, Restorative, Emergency Dental Services

The Dental Department provided dental services required to care for the individuals at LBSSLC, but did not implement an aggressive approach to periodontis. From 6/1/13 through 12/16/13, 103 individuals completed 140 appointments (duplicate count) for preventive care. From a document entitled: "Lubbock State Supported Living Center: Preventative Care," 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 following was the breakdown per month of the number of prophylactic care treatments completed:

Month	Number of Preventive Care Treatments	Month	Number of Preventive Care Treatments
June 2013	27	October 2013	26
July 2013	19	November 2013	22
August 2013	9	December 2013	10
September 2013	27	**Total**	**140**

Sixteen individuals underwent restorative care during 17 appointments. The following were the number of visits per month for restorations, and the total number of restorations completed per month, based on a document submitted entitled: "Lubbock State Supported Living Center Restorative Care: 6/1/2013-12/16/13:"

Month	Number of Visits	Number of Restorations Per Visit	Total Number of Restorations for Month
June 2013	8	1-8	24

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July 2013	3	1-3	6
August 2013	4	3-4	14
September 2013	1	4	4
October 2013	1	5	5
November 2013	0	NA	0
December 2013	0	NA	0
Total	**17**		**53**

The original submitted document did not indicate the number of fillings/restorative work completed at each visit. The document stated "restorative – filling." This information was submitted as an additional request.

From a document entitled: "Monthly Dental Emergency Log," dated 6/1/13 to 12/16/13, 13 individuals were seen and treated for 21 dental emergencies:

Month	Number of Emergencies	Resolved	Month	Number of Emergencies	Resolved
June 2013	1	1	October 2013	7	7
July 2013	4	3	November 2013	3	3
August 2013	0	0	December 2013	1	1
September 2013	5	5			
Total	10	9		11	11

There remained one individual seen for an emergency visit on 7/23/13, for which no evidence of follow-up was submitted.

From a document entitled: "Extractions: June 1, 2013 to December 15, 2013," two individuals underwent dental extractions. The number of teeth extracted per individual ranged from three to four per visit. The following information provided the breakdown by visit and numbers of teeth extracted per visit:

Month 2013	Number of visits with extractions	1 tooth extracted	2 teeth extracted	3 teeth extracted	4 teeth extracted	5 or more teeth extracted
June 2013	0	0	0	0	0	0

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July 2013	2	0	0	1	1	0
August 2013	0	0	0	0	0	0
September 2013	0	0	0	0	0	0
October 2013	0	0	0	0	0	0
November 2013	0	0	0	0	0	0
December 2013	0	0	0	0	0	0
Total	**2**	**0**	**0**	**1**	**1**	**0**

From a document entitled: "Annual Exams completed and previous, June 1, 2013 – December 17, 2013." Eighty-four individuals completed an annual dental exam during this time period. The following number of annual exams were completed per month:

Month	Number of Completed Annual Exams
June 2013	5
July 2013	7
August 2013	18
September 2013	26
October 2013	17
November 2013	8
December 2013	3
Total	**84**

It was noted that 43 of 84 (51%) were completed during four days during this time period: August 1, 2013 (14); September 11, 2013 (8); September 12, 2013 (11); and October 16, 2013 (10). It was unclear whether all of the exams were done on these four days, or if the documentation was completed on these days. It is recommended that the QA Department review the quality (i.e., comprehensiveness, detail in recording, etc.) of documents completed during these four days in comparison to annual assessments completed at other times. If the documentation was completed for several assessments at one time, there was the risk of wrong entries, lack of sufficient detail, and omission of information obtained during the exam. If this number of exams were completed in one day and not just the documentation, then the quality of the exams also needed review.

<u>X-rays</u>
From a submitted document entitled: "Individuals in need of radiographs," undated but scanned 12/9/13, there were five individuals for whom the risk (due to medical

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		conditions) of obtaining radiographs outweighed the benefit. For one additional individual, the family requested the radiographs not be completed through the Hospital Dentistry Program, and x-rays were not completed. According to the document, all other individuals in need of radiographs have received them. <u>Edentulous individuals/dentures</u> Information submitted in an untitled document, updated 12/5/13 indicated 16 individuals residing at LBSSLC were edentulous, for a rate of 16 out of 202 (8%). No individual became edentulous in 2012, or 2013. Two individuals became edentulous in 2011. Three individuals became edentulous in 2010. Two individuals became edentulous in 2009. Three individuals became edentulous in 2008. Six individuals became edentulous in, or prior to, 2007. It was noted that the 12/5/13 data indicating a total of 16 edentulous individuals was not in agreement with the 15 edentulous individuals from 11/15/13 data (i.e., Facility Oral Hygiene Data November 15, 2012 through November 15, 2013). That one more individual was edentulous from 11/15/13 to 12/5/13 was not further discussed. The list of 16 did not indicate there was a newly-admitted individual that was edentulous, indicating that the 11/15/13 data appeared to be incomplete. The reason for the discrepancy between databases could not be determined, but the Facility should identify the cause, and provide a brief explanation when submitting data with different results in order to provide clarity. Two of 16 individuals that were edentulous had dentures. One individual received dentures prior to admission at LBSSLC and one individual received dentures at LBSSLC. Fourteen individuals that were edentulous did not have dentures. Reasons given were: ▪ One - inadequate cooperation for denture fabrication to be completed; ▪ Thirteen - complex oral anatomy; ▪ Twelve - inadequate muscle coordination, tongue thrusting and other uncontrolled muscle movements, dysphagia, or excessive gag reflex; ▪ Fourteen – no demonstration of interest; ▪ Zero - prior poor dental experience; and ▪ Zero - undergoing dental procedures that may lead to dentures in the future. Some individuals had more than one reason listed for not having dentures. There was no information on how lack of demonstration of interest was measured or recorded. There was no information regarding whether the IDT met to discuss dentures in these 16 individuals and whether there was agreement not to pursue dentures. There was no information concerning the Legally Authorized Representative (LAR)/family member involvement in the decision process for pursuing dentures or not.	

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		General Anesthesia/TIVA	

Month	Number of Completed Visits with General Anesthesia/TIVA	Number of Scheduled Visits with general Anesthesia/TIVA Not Completed	Percent Completion Rate	Procedure Completed at Area Hospital
June 2013	11	2	82%	1
July 2013	7	5	29%	1
August 2013	8	1	88%	1
September 2013	9	1	89%	2
October 2013	10	6	40%	5
November 2013	17	4	76%	0
December 2013	7	6	14%	0
Total	**69**	**25**	**64%**	**10**

The active record was submitted for five individuals who had undergone general anesthesia/TIVA from August through December 2013. The procedures under general anesthesia/TIVA included one or more of the following: preventive care (i.e., deep scaling, root planing, radiographs, annual exam, restorations, and biopsy). Review of these records revealed the following:

- Consent by the guardian/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 current HRC review and approval was submitted in five of five (100%).
- A pre-operative medical clearance was completed and submitted in zero of five (0%) cases.
- 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%) cases.
- For those with teeth, a periodontal chart/periodontal screening record was submitted for zero of five (0%).
- The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score, Aldrete Score, or other equivalent assessment was submitted in four of five (80%) of the active records. For one record, the first page of the anesthesia record was submitted, but the second page (i.e., the location of the post anesthesia score) was not submitted.
- A post-operative vital sign flow sheet was submitted in zero of five (0%).
- Pain medication was prescribed in zero of five cases. It was noted that there were no extractions in the five submitted cases.

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		▪ An annual dental assessment was completed while under general anesthesia/TIVA in five of five (100%) cases. However, copies of these were not submitted as evidence of completion. <u>Extractions</u> For three individuals that underwent extractions on campus, the dental record was submitted (there were only three individuals with extractions in the prior six months). The following findings were made: ▪ From the submitted documentation, guardian/LAR consent was current in three of three (100%). ▪ HRC approval for time period of the extraction was submitted for two of three (67%). ▪ A dental IPN/DPN, indicating the need for extractions, was documented in zero of three (0%). Although the rationale for the extraction is usually documented either pre-operatively or at the time of exam under general anesthesia/TIVA, the template used did not include entries for the reason for the extractions. ▪ For three of the three cases, IV sedation/general anesthesia was used. ▪ From one to three teeth were extracted at a visit. ▪ Pain medication was documented as having been prescribed in one of three (33%) cases. There might have been additional orders for pain medication, but these documents were not submitted (i.e., dental post op orders, etc.). Only one of three included notation of pain medication prescribed on the IPN/DPN. ▪ A follow-up dental note the following workday or phone call to the residence was documented in one of three (33%) cases. ▪ A follow-up visit was documented in two of three (67%) cases to determine healing or complications. <u>Oral Surgery Offsite</u> Records of the five most recent offsite oral surgery consultations were requested. The response was that LBSSLC had an oral surgeon on staff at the Facility, and that all oral surgery was completed on campus. However, various other data sources, as well as discussions at LBSSLC, indicated a percentage of individuals were referred to an area hospital for oral surgery. There appeared to be a misunderstanding if there was no oral surgery done at area hospitals. At an earlier Monitoring Team visit, a number of cases had been referred to hospital based outpatient oral surgery. The QA/QI quarterly report of 10/15/13 referenced the Hospital Dentistry Program as an ongoing service to meet the needs of individuals requiring care at an area hospital. Based on the information previously provided, these individuals were selected for general anesthesia/TIVA in a monitored hospital setting where additional supports were available for the highest risk individuals due to comorbid conditions (e.g., severe	

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		respiratory compromise, cardiac conditions, etc.). For those individuals with such conditions that required procedures under general anesthesia/TIVA, the hospital dentistry program provided a needed service. The document "LBSSLC Attendance Tracking June 1, 2013 – December 16, 2103" did list the treatment provided to those individuals attending off-campus appointments. For some, this included deep scaling and root planing, along with x-rays, but no restorative care or extractions. Two individuals underwent a root canal. One individual underwent other restorative care (i.e., a filling). One individual had a gingivectomy. For those with severe periodontitis, an aggressive plan to reduce or eliminate the condition might allow selected individuals to not require general anesthesia/TIVA in the future. <u>Emergency Treatment</u> Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: swelling without pain, swelling with pain, broken tooth, filling fell out, and toothache (i.e., food impaction). The following findings are made based on this review: ▪ Five of five (100%) records documented the presence or not of pain. ▪ Pain was treated in four of four (100%) cases with documentation of this symptom. ▪ Follow-up occurred for four individuals. ▪ There was documentation of closure of the dental emergency (either no further visit required or scheduled for procedure) in five of five (100%) cases. ▪ The documented length of time from the notification of the dental emergency in the Dental Department to completing a visit varied from immediate intervention to six hours and 45 minutes. However, for one individual, the emergency visit DPN did not record the time, although the summary chart provided for the submitted folder included the time. It was not clear the source of the time provided when it was not located on the dental progress note. Additionally, for one individual, an RN Case Manager note was untimed the day prior to the dental visit for the emergency. There was documentation that the direct support professional called twice and the RN Case Manager once, but it was not clear from the note if the call was to the dental office or the QIDP. The RN Case Manager sent an email to the Dental Department about the need to see the individual. ▪ Additionally, for one individual, the dental note indicated allergies to Ibuprofen, yet this medication was prescribed for pain, according to the dentist's entry in an IPN. Based on submitted documentation, there was no further information, clarification, or monitoring for the order from the Dental Department, Pharmacy, or nursing staff. This suggested an error in documentation, or a breakdown in the system, because a medication that is prescribed when there is a known allergy should be rapidly identified and corrective orders/monitoring	

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		documented in the follow-up notes. The IPNs dating subsequent to this date did not indicate any knowledge of the allergy history, change in order, or monitoring for side effects. The Facility remained in noncompliance with this provision.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, 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.	This section of the report includes a number of subsections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> Policies developed, implemented, or revised since the last Monitoring Team visit included the following: ▪ "LbSSLC – Health Services: Dental Services Overview," dated 12/13/13 (R); and ▪ "LbSSLC – Dental Services: Oral Care," dated 12/13/13 (R). <u>Provision of Dental Records to IDTs</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence along with the copy from the dental office records. This was requested to assist in determining whether the IDTs received adequate/complete dental information for the individuals. However, the Dental Department did not submit the required documentation. The submitted documentation provided a copy of core documents (i.e., annual dental summary, dental progress notes, etc.) and listed where each document should be located in the dental office record, or the dental section of the active record. For instance, a copy of the Initial/Annual Examination Record included a comment that the original is in the Dental Record and a copy is in the Active Record. However, the request was to obtain a copy of the recent comprehensive exams in both the dental office record and the active record for comparison. This would provide the evidence to determine whether the two sets of documents were identical and whether the IDT was able to access these documents through the active record. This would require a copy of documents being obtained directly from the active record (not simply stating where the document should be located or accessed), and documents from the same time period from the dental office. No evidence was provided by the Dental Department for this aspect of the review. Due to this misinterpretation of the request, the percentage of documents located in the dental office record, that were also located in the dental section of the active record could not be determined for each individual submitted. Compliance could not be determined for this section. Although this concern was discussed in the Monitoring Team's last report for	Noncompliance

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		the July 2013 review, the requested information again was not submitted. This concern was also noted in QA reviews provided for this Monitoring Team visit. Refusals/Missed Appointments A review of information from a document entitled: "LBSSLC Refusals last six months 6/1/2013-12/16/13" for dental appointments indicated that five initial appointments were refused. Additionally, one follow-up appointment scheduled to complete the initial appointment was refused. Five individuals refused these six initial and follow-up appointments. The five initial missed appointments were completed in all five cases, and there were no pending appointments. Reasons for the scheduled appointments that were refused included: preventive care (three appointments), preventive care under TIVA (two appointments), and an annual exam (one appointment).	

Month	Number of Refused Appointments
June 2013	0
July 2013	0
August 2013	1
September 2013	1
October 2013	0
November 2013	2
December 2013	2
Total	**6**

For the six appointments that were refused, a follow-up appointment was completed in three cases.

- For two individuals, the completed appointments occurred from one to 15 days after the refused appointment.
- For zero individuals, the completed appointment occurred from 16 to 30 days after the refused appointment.
- For zero individuals, the completed appointment occurred from 31 to 60 days after the refused appointment.
- For one individual, the completed appointment occurred more than 60 days after the refused appointment.
- Three individuals had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document.

Requested were copies of ISPs and ISPAs in response to repeated dental appointment refusals. The Dental Department indicated there were no IDT meeting minutes in

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		developing strategies for missed/refused appointments. According to the Dental Department, there were two recently identified individuals with a pattern of refusal of dental appointments. However, this Dental Department document (undated) indicated the IDT had not met in response to the concern. A separate document indicated there was no ISPA log that tracked missed appointments. <u>Non-refusals/Missed appointments</u> The Facility submitted a document entitled: "All Missed and Refused Dental Appointments, reporting dates: 5/1/2013-11/15/2013." During this time period there were 54 missed/no show appointments, which were not categorized as refusals. Reasons for the scheduled appointments that were missed included preventive (13 appointments), preventive and TIVA (17 appointments), annual exam (15 appointments), TIVA, exam and preventive (one appointment), preventive and x-rays (one appointment), TIVA, preventive, and X-rays (three appointments), preventive and restoration (one appointment), prosthetic procedure (one appointment), and emergency (two appointments). The missed/no show appointments occurred in 15 residences. The major reasons identified for missed appointments included: illness (four), behaviors (15), medical clearance (five), not NPO (12), dental clinic reasons (four), the individual went to work (eight), the individual slept in (one), two appointments were scheduled at the same time (two), furlough (two), and lack of approval by the HRC (one). Listed were seven missed appointments that appeared to have been refusals: behaviors (four), and individuals went to work (three). Based on this submitted information, seven of the 54 missed appointments were refusals, and the missed non-refusal appointments totaled 47. A separate document entitled: "LBSSLC No shows/Missed appointments," undated, provided follow-up appointment information when the initial appointment was missed. However, the timeframe of the information was not provided.	

Month	Number of Missed Appointments (Non-refusals)
May 2013	9
June 2013	8
July 2013	5
August 2013	6
September 2013	3
October 2013	14
To November 15, 2013	2
Total	**47**

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		For the 55 initial appointments that were missed according to this document, a follow-up appointment was documented in 37 cases. ▪ Six individuals missed a follow-up appointment for completion. ▪ For five individuals, the completed appointments occurred from one to five days after the missed appointment. ▪ For 11 individuals, the completed appointments occurred from six to 15 days after the missed appointment. ▪ For two individuals, the completed appointments occurred from 16 to 30 days after the missed appointment. ▪ For eight individuals, the completed appointment occurred from 31 to 60 days after the missed appointment. ▪ For three individuals, the completed appointment occurred more than 60 days after the missed appointment. ▪ Two cases remained pending, as the appointment was scheduled, but had not yet occurred. ▪ Nineteen individuals had not been scheduled for a repeat appointment. Reasons provided included isolation or not medically cleared. A reason for follow-up was not documented in five cases. The Dental Department provided a narrative report for each month's analysis of missed appointments. These reports indicated the number of missed appointments and the number cancelled. The reason for the missed/cancelled appointments was listed. Information as to a follow-up appointment and/or appointment completion was also addressed. Submitted reports were for June 2013 through November 2013. There was no comment as to steps taken by the Dental Department for recurring concerns, such as the individual not remaining NPO prior to the appointment. In summary, for the period of time from June 1, 2013 through December 16, 2013 (from "LBSSLC Attendance Tracking June 1, 2013 – December 16, 2013"), there were a total of 321 dental appointments scheduled. Two hundred fifty-eight appointments were completed (80%), and 63 appointments were refused or missed for various reasons (20%). There were 11 off-campus appointments scheduled during this time. Eight of 11 (73%) were completed. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. From a document entitled: "LBSSLC June 1, 2013 – December 16, 2013," not further named but listing total appointments, anesthesia cases, and percentage using anesthesia, for the prior six months (June 1, 2013 through December 16, 2013), there were 260 completed appointments. The reason for the difference in numbers compared to the prior reference	

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		was not indicated. The dental office did not use mechanical restraints. Additionally, the dental office did not use oral sedation. Sixty-four of 260 (25%) completed appointments utilized general anesthesia/TIVA. From a document entitled: "Restraint and Sedation Tracking System," the Dental Department indicated it did not track restraint and sedation use. The Dental Department indicated that the Human Rights Officer and the QIDPs logged this information, but the Dental Department did not track use of restraints. The Dental Department did provide updated information concerning restraints to these departments. There had been no correspondence between the Dental Department and other departments concerning restraint or sedation use in the prior six months. Separately, a list of HRC approved dental and medical restraints was submitted, including the use of sedation, undated but with a scan date of 12/9/13. A total of 118 individuals were listed that required dental sedation. Thirty-two were approved for dental restraints. One hundred and four had approval for general anesthesia/TIVA alone, 17 had approval for oral sedation alone, and four had approval for both oral sedation and general anesthesia/TIVA. Thirteen consents were outdated. As of 12/9/13, there were 130 current consents for dental restraints or sedation. *Desensitization* The Facility submitted a document entitled: "Skill Acquisition Programs: Instructions for SAP Development – LBSSLC 9/21/12 (10/28/13R) (11/15/13R)." This document provided step-by-step guidance for the IDT and other staff in development of SAPs. A document entitled: "Desensitization Plans Summary" (undated) was submitted providing current information concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits. Additional SAP data was requested onsite. The following information was provided, based on these document requests: ▪ There was no total number of individuals on campus that had been identified as requiring desensitization or other plan to reduce the need for restraint or use of TIVA/general anesthesia. However, given the fact that 130 consents currently existed for dental restraints or sedation, considerably more work was needed than what is described below. ▪ Six individuals had dental desensitization plans developed and implemented for suction tooth-brushing skill acquisition programs. Implementation dates ranged from 5/30/13 to 10/16/13. o Six of six of these suction tooth-brushing skill acquisition programs included data to verify implementation. o Zero of six of these suction tooth-brushing skill acquisition programs included trend analysis of progress. ▪ Six individuals had dental desensitization plans developed and implemented for	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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tooth-brushing skill acquisition programs. Implementation dates ranged from 8/19/13 to 10/14/13. For two individuals, the skill acquisition program was not dated.

Five of six of these tooth-brushing skill acquisition programs included data to verify implementation.
Zero of six of these tooth-brushing skill acquisition programs included trend analysis of progress.

One individual also had a medical/dental appointment desensitization plan for an office visit skill acquisition program. This plan was undated.

For this one plan, there was no submitted data to verify implementation.
For this one plan, there was no submitted data indicating trend analysis of progress.

Information about the specific implementation of 11 SAPs follows, along with the submitted months of data:
<table>
<tr><th>Name of SAP</th><th>Date of implementation</th><th>Months of data submitted</th></tr>
<tr><td>Calendar skill acquisition</td><td>7/22/13</td><td>December 2013</td></tr>
<tr><td>Duration of tooth-brushing</td><td>8/19/13</td><td>November 2013</td></tr>
<tr><td>Duration of suction tooth-brushing</td><td>6/19/13</td><td>November 2013</td></tr>
<tr><td>Tooth-brushing</td><td>8/21/13</td><td>November 2013</td></tr>
<tr><td>Duration of suction tooth-brushing</td><td>5/30/13</td><td>November 2013</td></tr>
<tr><td>Duration of suction tooth-brushing</td><td>9/30/13</td><td>November 2013, December 2013*</td></tr>
<tr><td>Duration of suction tooth-brushing</td><td>10/16/13</td><td>November 2013, December 2013</td></tr>
<tr><td>Dental Desensitization SAP</td><td>10/14/13</td><td>October 2013, November 2013</td></tr>
<tr><td>Duration of suction Tooth-brushing</td><td>7/2/13</td><td>October, November, December 2013</td></tr>
<tr><td>Tooth-brushing</td><td>7/8/13</td><td>July, September 2013, one undated month</td></tr>
<tr><td>Tolerance suction tooth-brushing</td><td>6/26/13</td><td>November 2013</td></tr>
</table>
*Data was incomplete

A meeting occurred during the Monitoring Team's visit to discuss pre-treatment sedation, dental desensitization, and use of TIVA/general anesthesia. During this
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		meeting, the Dental Director estimated 25 percent of individuals were able to cooperate with exam and preventive care in the dental office without TIVA/general anesthesia. Seventy-five percent would require this, in part due to severe periodontitis and the severe discomfort/pain produced during deep scaling and root planing. It was also stated that once this was done, that a maintenance program could be developed and the individual would not potentially need general anesthesia again. A review of the dental records indicated that following dental treatment under anesthesia, treatment plans referred to future exam and cleaning under general anesthesia. There was no evidence that there was an aggressive approach to begin desensitization or engage in other strategies to allow cooperation with exam and cleaning in the dental office. For some individuals, there might be need for future appointments under general anesthesia until cooperation can be attained, but there was no evidence of a plan. The Dental Department failed to provide preventive care that included a program to improve cooperation for routine exam and cleaning. All individuals undergoing general anesthesia should have a quality plan created and implemented, that is documented in the residence on a daily basis, and includes frequent visits to the dental office for monitoring of appropriate implementation of the plan and includes office staff in SAP participation. This component would ideally occur one to three times weekly in the office setting. Although it might take years for significant cooperation, there is need for the Dental Department to prove that the individual can only undergo quality dental care with general anesthesia by demonstrating lack of progress over months/years despite an aggressive dental desensitization program. According to a dental scan call of 4/17/13, examinations and cleaning should fall under the category of routine procedures. However, there were several individuals placed under general anesthesia that did not have anything more than exams and cleaning. For those individuals that did require more extensive procedures, the challenge would be to improve the oral hygiene so that deep scaling and root planing is not needed, and office hygiene procedures would not require general anesthesia. The literature continues to indicate risks of adverse effects associated with general anesthesia (and the physiologic stress of the peri-operative period) in those that are elderly or have dementia, including short and long term cognitive decline. There is less information concerning aging adults with intellectual/developmental disabilities (IDD) and the effects of general anesthesia. However, there is the potential for risk of such side effects with general anesthesia in the adult IDD population, and it would be important to avoid such risks until the benefits are clearly indicated. The cumulative risk of having individuals undergo general anesthesia yearly (or more frequently) or every two years is not known, but is concerning Improving oral hygiene to allow office cleaning would	

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		decrease the number of individuals needing general anesthesia as well as the length of time under anesthesia. The use of general anesthesia for dental care in this population at LBSSLC appears to not necessarily be focused on the safety and health of the individual. While the discomfort of deep scaling and root planing might require general anesthesia once such procedures are needed, the dental care system has failed individuals by allowing their dental health to deteriorate to the point of requiring general anesthesia for dental preventive care and examination. Once assigned to a category needing general anesthesia, it was determined that no dental desensitization or other behavior programming was needed. There was no further time or effort devoted to developing a consistent individualized program to reduce apprehension and anxiety in the dental chair, and allow for cooperation for "routine" dental procedures at some point in the future, as well as a quality tooth-brushing program in the home. TIVA and general anesthesia are the most invasive and restrictive of all approaches, yet oversight of use appeared lacking. It was being used as a primary step rather than a last resort after less restrictive and safer approaches had been proven ineffective. It is recommended that the Facility review the current process, and ensure a rigorous desensitization/behavioral program and/or other strategies are in place, with quality data, and quality analysis, for those who have undergone procedures under general anesthesia, those scheduled in the future, or those that have treatment plans indicating routine exams under general anesthesia. Criteria should be developed concerning the steps needed for each individual to attempt to reduce the severe periodontitis, and/or reduce the individual's resistance to dental care. This should include consistent implementation, and regular review of the implementation of the plan. If despite implementation, the plan has been unsuccessful in reducing the periodontitis, and the individual will require general anesthesia/TIVA, then the IDT should meet to approve the use of general anesthesia/TIVA, and revise the plan for after the procedure to again attempt to reduce the need for general anesthesia/TIVA. The goal should be to reduce severe periodontitis to the point where TIVA/general anesthesia is only needed for extractions and extensive restorative work. Again, the continued need for deep scaling and root planing for numerous individuals demonstrates a lack of support systems are in place for dental preventive care. The Dental Department submitted a policy entitled: "LbSSLC – Health Services: Dental Services Overview," dated 12/13/13 (R). The policy stated: "If medical restraint or sedation is required for routine dental care (examination or prophylaxis) for an individual with behavioral supports, the health care professional will attempt to minimize or eliminate the need for their use. A desensitization plan will be the prudent	

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		program implemented to minimize or eliminate the need for use of restraint or sedation." The Dental Department provided no evidence for minimizing or eliminating the need for general anesthesia and TIVA, and thus was not following its own policy. In summary, a rigorous oral hygiene program would need to be in place to reduce the need for painful procedures, but there had been no action taken to begin such a program for individuals using general anesthesia and TIVA. There is clearly a needed role for use of general anesthesia and TIVA in providing invasive dental procedures. However, it was the Dental Director's estimate that approximately 75 percent of the population will undergo periodic exams and preventive care under TIVA/general anesthesia without attempting to improve the cooperation of the individuals in completing routine dental care and without a long-range plan to improve oral hygiene to the point where anesthesia is not needed. This is highly problematic for a population in a large facility with numerous resources to create and implement plans to ensure optimal care and safety of the individual. <u>Quality Assurance/Improvement Initiatives</u> The QA/QI Department used the following monitoring tool to review the quality and completeness of dental care: "Dental Monitoring Tool," undated. This tool included 24 specific indicators of dental services. The Dental Department met monthly with the QA nurse. Meetings were held 6/28/13, 7/29/13, 9/27/13 (two meetings were held, one to review the July 2013 data, and the second to review the August 2013 data), 10/23/13, and 11/21/13. The following review provides some of the contents of these meetings. The Dental Department did not provide any internal monitoring. The QA nurse completed an audit on 20 percent of the prior month's appointments, using a random sample methodology. As only the QA nurse completed the audit, and not a member of the Dental Department, there was no inter-rater reliability. The 6/28/13 meeting reviewed the April 2013 data. Prior strengths identified included documentation of oral screen at the time of the annual assessment, as well as preventive care. The annual dental summary form had been revised to include comment for oral hygiene instructions. Areas needing improvement included sustaining the progress made with oral cancer screening documentation and preventive care documentation. The minutes of this meeting, indicated for May, oral cancer screening documentation had decreased to 50 percent and preventive care instructions was 75 percent. Documentation justifying extractions was an area needing improvement. The May 2013 data also indicated that the direct support professional had documented preventive oral	

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		care zero percent of the time. The 7/29/13 meeting minutes for June data (it was not clear if the data was from May or June 2013 as the sample was from appointments in May, but June 2013 annual or initial exam forms were referenced), indicated that for June 2013, the annual or initial exam form was completed at the time of exam in only 12.5% of cases. The treatment plan was completed at the time of the actual exam in only 11% of cases. Additional concerns listed the lack of documentation for justification of extractions. The 9/27/13 meeting minutes for the July data, documented that the June 2013 data was obtained by a random sample of dental appointments. The data indicated the annual dental summaries were submitted for the ISP process in a timely manner 100% of the time. Concerns included documentation of justification for extractions. It was noted that only 75% of the annual or initial exam forms were completed at the time of the exam, and only 87% of the treatment plans were completed at the initial or annual examination. Direct support professionals continued to have zero percent compliance with documenting preventive care. The 9/27/13 meeting minutes, reviewing the August data, documented continued challenges. Fifty-seven percent of the annual dental exams were completed within 365 days. Fifty percent of individuals' initial or admission exam included oral cancer screening. Only 71 percent were provided with oral hygiene instructions. Dental treatment plan completion at the initial or annual exam was 75 percent. The direct support professionals continued to have zero percent compliance with documenting preventive care. The 10/23/13 meeting minutes indicated improvement in oral cancer screening. Continued challenges included providing oral hygiene instructions (i.e., 50 percent compliance). Only 33 percent of those undergoing TIVA had a completed anesthesia record. Direct support professional compliance with documenting preventive care continued at zero percent. The 11/21/13 meeting minutes indicated areas of improvement remained similar to prior concerns. Providing oral hygiene instruction was at 63 percent compliance, obtaining anesthesia records was at 50 percent compliance, and direct support professional/nursing documentation of preventive care was zero percent. In response to the lack of direct support professional documentation of oral care, oral care was to be added to the treatment record. This was to in-serviced and implemented on 12/1/13. The Dental Department listed several advances due to the dental QA monitoring process.	

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		These were all documentation improvements and included the following: ▪ In response to lack of a second opinion for extractions, a revision of the dental progress note extraction form was to include a line for a second opinion. ▪ In response to the lack of the annual dental assessment being found in the active record, the Dental Department began to place the annual dental assessment in a plastic sleeve in the dental section of the active record. There was concern this document was being removed from the active record. ▪ In response to the lack of documentation of justification for extractions, the dental progress note extractions form was revised to include a justifications section. ▪ For those treated under TIVA/general anesthesia at the local hospital with lack of anesthesia records being forwarded to LBSSLC, this was identified as a concern and the resolution was outstanding. ▪ Due to absence of oral hygiene instructions being given, the dental hygienist's dental progress note template was revised to specify whether oral care instructions were provided to the individual, the staff, or both. ▪ Due to the lack of direct support professional documentation of oral care, a new process was developed and implemented to improve in this area. Although not listed in this summary document, it was to include an entry space in the treatment record. From the information provided in this report, there was insufficient detail to determine if the plans to use the treatment record was ongoing or another process had been developed. ▪ As the QA nurse found the dental treatment plan was not on the Active Record, it also was to be placed in the plastic sleeve under the Dental Section of the active record. ▪ There was the notation that the Dental Director reviewed findings of the QA nurse and implemented changes based on the cause. The Dental Director believed that approach worked better than having a second auditor from the Dental Department involved in QA, which would allow for inter-rater reliability. Currently, only the QA nurse provided monitoring of the Dental Department and inter-rater reliability was not possible. The hard copy of the Presentation Book provided a section entitled "Monitoring Tools," as well as examples and analysis of information. However, the tools were designated as draft, and the examples were all from 2011. Additionally, the undated page of "inter-rater data" discussed remote information no longer applicable, as the more current information indicated there was a decision not to proceed with inter-rater reliability. Similarly, the "Dental Clinic Cancellations and Analysis" report analyzed old data, from 3/23/11 through 8/31/11. When reviewing the entire book, it appeared this was an old copy from 2011. The only updated information was a copy of the Action Plans and	

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		Provision Action Information for Section Q, updated 12/17/13, and placed in the back of the hard copy of the Presentation Book. The lack of review of submitted information (i.e., supplying an outdated version from 2011) by the Dental Department was concerning. An electronic copy of the Presentation Book Section Q was forwarded. This included the necessary current information. <u>Dental Policies and Procedures</u> From a document entitled "Policies and Procedures Addressing the Provision of Dental Care," the Dental Department indicated there were no new policies. It was also stated that the policies provided to the Monitoring Team at the last visit had been "condensed" to four policies. The QA Department provided two revised policies applicable to dental services, which might have reflected the "condensing" of dental policies.	

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 For 20 individuals (i.e., Individual #274, Individual #20, Individual #30, Individual #313, Individual #26, Individual #160, Individual #267, Individual #164, Individual #179, Individual #45, Individual #132, Individual #130, Individual #51, Individual #6, Individual #77, Individual #306, Individual #109, Individual #119, Individual #185, and Individual #156), 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); o SLP assessments for four individuals newly admitted to LBSSLC: Individual #85, Individual #98, Individual #88, and Individual #91; o SLP assessments for eight additional individuals: Individual #226, Individual #323, Individual #53, Individual #74, Individual #264, Individual #99, Individual #155, and Individual #60; 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; o Minutes for Speech Department meetings held since the Monitoring Team's last review; o List of all general common area communication devices; o Blank communication competency-based performance check-off for individual-specific communication programs; o Completed audits of SLP documentation; and o Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review. ▪ **Interviews with:** o Linda Thomas, Director of Habitation Therapy; o Stacie L. Duda, MS, CCC-SLP; and o Samantha M. Russell, MS, CCC-SLP. ▪ **Observations of:** o Individuals with AAC devices in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 12/20/13. 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. Based on a review of the Facility Self-Assessment, as well as interview with the Director of HT, the following was found: ▪ In September 2013, the Facility began tracking key indicators. The Administrative Outcome Measure document included data that had been collected for the months of September, October, and November 2013. The key indicators for Section R were: o Physical, Mental and Behavioral Health and Well-Being ▪ Percentage of scheduled assessments for all clinical disciplines completed within the required time frame; ▪ Number of residents that have a current Integrated Health Care Plan; The tracking and trending of QA/QI key indicators for Section R was a step in the right direction. However, additional work will need to be completed in the development of methodologies, standards, and criterion to support accurate reporting with these key indicators. As was illustrated during the QA/QI Council meeting that members of the Monitoring Team attended, because a methodology had not been provided for calculating the results of the first indicator listed above, the wrong formula had been used, and it resulted in a difference between a two percent rating as the HT Director reported, and the 100 percent rating, which is what it should have been. In addition, more work was needed to develop key indicators that would show actual outcomes for individuals (e.g., percentage of individuals with AAC devices that increased their level of communication), as well as quality of supports (i.e., as opposed to just timely completion or presence of an IHCP).

	▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Facility-developed audit tool for SLP assessments, Communication Compliance Monitoring form, and HT databases. The Facility was not using the State Settlement Agreement Monitoring Tool for Section R. o The monitoring tool and audits did not include adequate methodologies (e.g., observations, record review, and staff interview). o The Self-Assessment identified the sample sizes, including sample sizes adequate to consider them representative. Section R samples were generated utilizing a Random Sample Generator. o The Facility-based audit tools (i.e., SLP assessment audit tool) did not include adequate instructions, including standards, and criteria. o The following staff/positions were responsible for the Settlement Agreement Monitoring Tool for Section R: the Director of HT and SLPs. Currently, no Facility PCMs were responsible for completing the Self-Assessment. The Director of HT and therapists were working with a Facility PCM to provide training in compliance monitoring. In the future, if data collected by a PCM it should be identified in the Self-Assessment. o Adequate inter-rater reliability had not been established between the Director of HT, SLPs, and the PCM. ▪ The data presented in the Self-Assessment reflected the completion of additional activities, such as tracking the completion of SLP assessments for individuals newly admitted to the Facility, using Protocol/Guideline to identify appropriate caseloads, review of current licensure and ASHA certification for SLPs, review of continuing education database, review of QIDP database for completion of assessments and attendance, etc. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment presented findings consistently based on specific indicators within subsections. ▪ The Facility rated itself as being in substantial compliance with Sections R.1 and R.2. This was consistent with Monitoring Team's findings. The Facility rated itself as not being in compliance with Sections R.3 and R.4, which also was consistent with the Monitoring Team's findings. ▪ The Facility data identified some areas in need of improvement, but did not provide specific information regarding the analysis of the information and/or the development of interventions to address findings that did not support compliance.
	Summary of Monitor's Assessment: The Facility had established a protocol that memorialized the process for determining Speech Language Pathologist (SLP) caseloads. There were an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. The SLPs were licensed to practice in the state of Texas and provided evidence of current American Speech-Language and Hearing Association (ASHA) certification. SLPs had completed continuing education directly related to communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components. The Facility was found to be in substantial compliance with Section R.1. Individuals who had been newly admitted to LBSSLC had a SLP assessment completed within 30 days,

	SLP/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions. The Facility was found to be in substantial compliance with Section R.2. ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' AAC systems and strategies for their use, as well as communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. Individual-specific training and performance check-offs had been developed and implemented for one individual with an AAC system in the sample. The Facility had policies/procedures related to monitoring communication supports provided to individuals. The Facility Self-Assessment for Section R.4 indicated: "this provision is not in compliance as there needs to be additional focus on the monitoring as well as efficacy monitoring which is in the initial stages." This was consistent with the Monitoring Team's findings.

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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 expressive or receptive language disorders with assessments completed in the last 12 months, including the following ten individuals: Individual #226, Individual #323, Individual #53, Individual #74, Individual #264, Individual #99, Individual #155, Individual #60, Individual #26, and Individual #6; ▪ **Sample R.2:** Three individuals receiving direct speech interventions including: Individual #274, Individual #20 and Individual #30; ▪ **Sample R.3:** Seven individuals with a PBSP and communication deficits, including: Individual #6, Individual #77, Individual #306, Individual #179, Individual #185, Individual #38, and Individual #156; and ▪ **Sample R.4**: Ten individuals with AAC devices including: Individual #313, Individual #26, Individual #160, Individual #267, Individual #164, Individual #179, Individual #45, Individual #132, Individual #130, and Individual #51. 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.	Substantial Compliance

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		Staffing Since the last review, the Protocol for Caseload Distribution for SLPs, dated 11/11/13, had been developed. The purpose of this document was to define SLP responsibilities, establish the SLP-to-individual ratio, and describe how SLP caseloads were to be created. SLP responsibilities were defined, but not limited to: "conducting assessments, developing and implementing programs, providing individual specific augmentative/alternative communication devices, providing assessment/treatment for dysphagia, providing staff training, monitoring and assisting the SAP [skill acquisition program] writers with information for programs related to communication." The caseloads for SLPs at LBSSLC were to be determined by the following: the Facility census and individuals identified with mild, moderate and severe language/communication deficits. SLPs specific skill sets also were to be considered. A ratio of 1:60 was instated to be considered with adjustments, as needed, for transition to a new home or the community, discharges, and/or death of an individual. The Provision Action Information document noted that as of 8/16/13, the Facility had four full-time SLPs. There were no SLP vacancies. The Facility SLP assigned caseloads were based on the requirements of the job and the acuity of the individuals in relation to identified communication needs (e.g., AAC systems). The SLP caseloads were reported as follows: ▪ SLP #1 had a caseload of 66 individuals. Fifty-four percent of the individuals on this caseload had severe communication/ language deficits, and 35% of the individuals had moderate to mild communication deficits. The SLP provided supports and services to 59 of these individuals with identified communication needs. The remaining seven individuals (11%) required a communication assessment every five years. ▪ SLP #2 had a caseload of 55 individuals. Twenty-seven percent (27%) of the individuals had severe communication/language deficits, and 53% of the individuals had moderate to mild deficits. Forty-four (44) of these 55 individuals had identified communication needs. The remaining ten individuals (18%) required a communication assessment every five years. ▪ SLP #3's caseload was 55 individuals. Eighty percent (80%) of these individuals had severe language deficits and 16% of the individuals had moderate to mild deficits. Fifty-three (53) of these individuals had identified communication deficits. The remaining two individuals (4%) required a communication assessment at least every five years. ▪ SLP #4's caseload had 30 individuals. Ninety-seven percent (97%) of these individuals had severe language deficits and the remaining 3% had moderate to mild communication deficits. This SLP also had PNMT responsibilities, as well as assisting SLP #1 and/or other therapists as needed.	

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		A review of the LBSSLC protocol, policies, and SLP caseloads (as well as other information discussed below) indicated there were an adequate number of SLPs 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. **Qualifications:** ▪ Four of four SLPs were licensed to practice in the state of Texas. ▪ Four of four SLPs had evidence of ASHA certification. **Continuing Education** Four of the four SLPs 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: ▪ 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); ▪ Least Restrictive Method of Eating (4/3/13); ▪ Mealtime Miseries: Management of Complex Feeding Issues (6/7/13 to 6/8/13); ▪ Effective Sensory Diets (6/18/13); ▪ Presentation of DynaVox Mayer-Johnson (10/16/13); ▪ With Every Breath You Take… Maintaining Pulmonology Health (10/24/13); ▪ Habilitation Therapies Annual Conference (i.e., Surgical Intervention and Case Studies for Dysphagia, GI Issues, Constipation and Sepsis, Oral Motor Assessment, Case Studies in Positioning for Dysphagia, Return to Oral Eating, AAC, Measurable Goals for Skill Acquisition Programs, Integrating Communication and Behavioral Supports, and Programming for Individuals Who are Deaf and Blind (10/31/13 to 11/2/13); ▪ Ventilator Application of the Passy-Muir Valve (4/11/13); and ▪ Beginning Sign Language Class (10/1 to 11/5/13). **Facility Policy** The Facility submitted the following policies and protocols: ▪ LBSSLC – IDT – Program Development: Speech Communication Services, revised 12/4/13; ▪ LBSSLC Protocol for Determining SLP Caseload, dated 11/11/13; ▪ LBSSLC Compliance/Efficacy Monitoring Guideline for Licensed Habilitation Therapists, dated 9/16/13; ▪ LBSSLC Individual-Specific Competency Based Training PNM and Communication Skills, dated 11/11/13;	

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		▪ LBSSLC Protocol to Identify Individuals Who Require Individual–Specific Competency-Based Training and are High Risk for Aspiration Pneumonia and/or Choking, dated 11/12/13; ▪ LBSSLC Protocol for Master Lists (i.e., Individuals who have received a Modified Barium Swallow study), dated 9/30/13; ▪ LBSSLC Protocol for Dental Department, dated 11/6/13; ▪ LBSSLC Protocol for Pathway for Return to Oral Eating and/or for Least Restrictive Intake, dated 1/8/14; and ▪ LBSSLC Protocol for Persons Who Have Individual-Specific Training Techniques, dated 10/21/13. The Facility-based SLP/communication policies and protocols did include the following: ▪ 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 of need 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 established a protocol that memorialized the process for determining SLP caseloads. The Facility employed an adequate number of SLPs with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. The SLPs were licensed to practice in the state of Texas and provided evidence of current ASHA certification. SLPs had completed continuing education directly related to	

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		communication and transferrable to the population served. The Facility SLP policies and protocols included necessary components as discussed within this section. The Facility was in substantial compliance with this provision.	
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 for Individuals Newly Admitted to LBSSLC** The Facility did not use a screening process, but rather conducted comprehensive assessments of newly-admitted individuals. Four of four (100%) newly admitted individuals (i.e., Individual #85, Individual #98, Individual #88 and Individual #91) received a communication assessment within 30 days of admission or readmission. The Communication Master Schedule indicated that all individuals had received a comprehensive communication assessment. Per policy, communication assessments of current status were to be completed using the following criteria: per the Master Communication Schedule according to the ISP schedule established by the Facility; according to the re-assessment date indicated on the communication assessments; and/or as indicated by need. **Communication Assessment** The ten SLP assessments reviewed for the individuals in Sample R.1 were current within the last 12 months. Based on review of the individuals in Sample R.1, the following provides the details of the comprehensiveness of the communication assessments: ▪ Ten of 10 individuals' speech and language (SL) assessments (100%) 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; ▪ Ten of 10 individuals' SL assessments (100%) 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. ▪ Ten of 10 individuals' SL assessments (100%) incorporated a description of	Substantial Compliance

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		verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Ten of 10 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ Ten of 10 individuals' SL assessments (100%) 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 SAP writers and IDT members for direct interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) included the effectiveness of current supports, including monitoring findings. However, as discussed with regard to Sections R.3 and R.4, this was limited, because the Facility did not yet have a fully functioning system to monitor the provision or effectiveness of supports (i.e., monthly notes that evaluated progress based on data); ▪ Ten of the 10 individuals' SL assessments (100%) 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; ▪ Ten of 10 individuals' SL assessments (100%) offered a comparative analysis of health and functional status from the previous year. For these individuals, the SLP assessment provided an overview of an individual's health status over the past year. The therapist discussed the type of supports and services that had been implemented to minimize the impact on the individual's functional status; ▪ Ten of 10 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments. For these individuals, the SLP assessment provided an overview of the past assessment results with the current assessment data for communication function. The assessment analysis discussed if the individual's communication performance had remained the same, had improved, and/or had 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 assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule;	

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		▪ Ten of 10 individuals' SL assessments (100%) supplied a monitoring schedule; ▪ 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; 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. Twenty-three of the 23 SLP assessment elements (100%) were present in each of the ten assessment reviewed. **<u>SLP and Psychology/Behavioral Health Services Specialists Collaboration</u>** The LBSSLC – IDT –Program Development: Speech/Communication Services procedure memorialized the following SLP responsibilities in achieving collaboration with Psychologists/Behavioral Health Specialists: ▪ During the completion of SLP assessments, SLPs were responsible for reviewing individuals' PBSPs and referencing the PBSPs in the assessment; ▪ SLPs were to provide input to Psychologists/Behavioral Health Services Specialists to assist in the development of communication strategies for behavioral support/interventions; and ▪ SLPs were to attend the Behavior Support Committee (BSC) to collaborate and provide input to assist in the development of communication strategies for behavioral support/interventions. Based on a review of seven individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Seven of seven individuals' communication assessments and PBSPs (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Seven of seven individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 7/15/13 to 10/31/13, participation by a SLP was noted in 14 of the 16 meetings	

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		(88%). In summary, individuals who had been newly admitted to LBSSLC had a SLP assessment completed within 30 days, SLP/communication assessments included necessary components, and SLPs and Psychologists/Behavioral Health Specialists were collaborating in the development of individual-specific communication strategies for behavioral support/interventions. The Facility was in substantial compliance with this provision.	
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 a review of the ISPs for ten individuals in Sample R.4, the following was noted: ▪ Seven of 10 individuals' SLP (70%) (i.e., Individual #313, Individual #26, Individual #160, Individual #179, Individual #45, Individual #130, and Individual #51) attended the annual ISP meeting. Individual #267's ISP Preparation meeting documentation required the attendance of a SLP, but an SLP did not attend. ISP Preparation meeting documentation was not available for Individual #164 and Individual #132. ▪ Five of 10 individuals ISPs (50%) (i.e., Individual #267, Individual #164, Individual #132, Individual #130, and Individual #51) 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. The missing component for the five remaining individuals was a description of how staff were to support functional communication with the individual's AAC system. ▪ Communication Dictionaries for four of 10 individuals (40%) (i.e., Individual #313, Individual #26, Individual #267, and Individual #45) were reviewed at least annually by the IDT as evidenced in the ISP and/or ISPA. ▪ Six of 10 ISPs reviewed (60%) (i.e., Individual #313, Individual #26, Individual #267, Individual #164, Individual #45, and Individual #130) 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. ▪ Three of 10 ISPs reviewed (30%) (i.e., Individual #164, Individual #45, and Individual #130) 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	Noncompliance

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		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. **Development and Implementation of Functional Individual-Specific Assistive Communication Systems** The Monitoring Team and Facility SLPs conducted observations in the homes and/or day programs of seven individuals (i.e., Individual #267, Individual #26, Individual #160, Individual #53, Individual #130, Individual #20, and Individual #164). ▪ Seven of seven observations (100%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for seven of seven individuals (100%) were noted to be in use in each observed setting. ▪ AAC systems for seven of seven individuals (100%) were portable. ▪ AAC systems for seven of seven individuals (100%) were functional. ▪ For seven of seven individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices** Since the last review, the SLPs reviewed all the general use AAC devices in individuals' residences, work sites and day programs to ensure the devices were functional and instructions were available for use. The Monitoring Team completed observations of some of these general AAC devices during observations of individuals. The SLPs described how revisions had been made to some of these devices that enhanced their function. Observations of general use AAC devices will continue during the next review. **Direct Communication Interventions** At the time of the review, three individuals (i.e., Individual #274, Individual #20 and Individual #30) were receiving direct speech therapy. Sample R.2 included these three individuals. A review of these individuals' records found the following: ▪ Two of three individuals' direct intervention plans (67%) (i.e., Individual #20 and Individual #274) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For one of three individuals' records reviewed (33%) (i.e., Individual #274), the current SLP assessment identified the need for direct intervention with rationale. ▪ For two of three individuals' records reviewed (67%) (i.e., Individual #20 and Individual #274), there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of three individuals (0%), information was present regarding whether	

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		the individual showed progress with the stated goal on a monthly basis. The monthly notes for these three individuals did not provide a summary of data to show objectively whether or not the individuals made progress on the specific objectives included in their programs, and, if not, what the causes might have been. ▪ For three of three individuals (100%), a description was found of the benefit of the device and/or goal to the individual. ▪ For two of three individuals (67%) (i.e., Individual #30 and Individual #20), a report was found regarding the consistency of implementation. ▪ For none of three 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 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 none of two individuals' records (0%) reviewed (i.e., Individual #20 and Individual #274), termination of intervention was well justified and clearly documented in a timely manner. Individual #30 had not been discharged from therapy. **Competency-Based Training and Performance Check-offs** 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** The Facility Protocol for Persons Who Have Individual-Specific Training Techniques, dated 10/21/13, defined the system for the development and implementation of the provision of individual-specific training. The protocol outlined the specific responsibilities of clinical licensed therapists, PNMP Coordinators, and Residential Coordinators. Each home was responsible for having a notebook that contained a staff roster of who required and had successfully completed individual-specific training, copies of individuals' PNMPs and dining plans, copies of staffs' completed performance check-offs, and copies of PNMP Coordinators' completed performance check-offs. Four SLPs and six PNMP Coordinators were approved trainers for communication non-foundational training. Therapists had determined that 28 individuals would require individual-specific training outside of the content of PNM foundational training. These 28 individuals were identified by a red dot on their PNMPs and dining plans. Staff were required to have	

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		individual-specific competency-based training prior to working with these 28 individuals. The staff of one of the 28 individuals within the samples for Section R (i.e., Individual #30) required competency-based training and performance check-off related to AAC/communication. ▪ Twenty-six of 26 staff (100%) assigned to Individual #30 had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills for AAC/sighted guide) prior to the provision of services. In summary, ISPs generally provided some description of individuals' communication skills. However, additional work was needed to include descriptions of individuals' AAC systems and strategies for their use as well as 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 and/or ISPAs to structure skill acquisition, and provide a mechanism to measure progress. Progress notes should include a summary of data to document progress and/or lack of progress. Individual-specific training and performance check-offs had been developed and implemented for one individual with an AAC system in the sample. The Facility remained out of compliance with this provision.	
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** As discussed with regard to Section R.1, the Facility's policies/procedures did 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** Four SLPs and six PNMP Coordinators used the Communication Compliance Monitoring form, implemented 4/15/13, to monitor staff communication with an individual before/during activities; that communication instructions were present, easily located and utilized; that the SAP for communication was being implemented as	Noncompliance

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		written/instructed; that the device was present, working and utilized; that staff were able to demonstrate how to support the individual in using the device; that staff were able to locate the AAC devices notebook and demonstrate use; that staff were able to explain risks associated with not implementing programs; that staff acknowledged being trained on individualized program; and that staff demonstrated where to document data correctly. Three months of Communication Compliance Monitoring forms were requested and reviewed for individuals in Sample R.4: ▪ For five of 10 individuals (50%), (i.e., Individual #160, Individual #26, Individual #313, Individual #132, and Individual #179) monitoring of communication supports was outlined in the assessment. ▪ For two of 10 individuals (20%) (i.e., Individual #267 and 313) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. In summary, the Facility had policies/procedures that incorporated the elements necessary for monitoring communication supports. The Facility Self-Assessment for Section R.4 indicated: "this provision is not in compliance as there needs to be additional focus on the monitoring as well as efficacy monitoring which is in the initial stages." This was consistent with the Monitoring Team's findings 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), 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 #136, Individual #184, Individual #65, Individual #109, Individual #111, Individual #170, Individual #140, Individual #245, Individual #40, Individual #87, Individual #308, Individual #97, Individual #271, Individual #139, Individual #3, and Individual #240; o For Section S.1, Dental and/or Medical SAPs for: Individual #276, Individual #258, Individual #217, Individual #109, Individual #232, and Individual #274: o For Section S.2, Individual Support Plans, Preferences and Strengths Inventory, Functional Skills Assessments, and Vocational Assessments, as available, for: Individual #276, Individual #155, Individual #22, Individual #109, Individual #67, Individual #80, Individual #46, Individual #87, Individual #172, Individual #174, Individual #77, and Individual #70; o For Section S.3, SAPs and SAP data sheets, as found in records during onsite visit, for: Individual #276, Individual #155, Individual #22, Individual #109, Individual #67, Individual #80, Individual #46, Individual #87, Individual #172, Individual #174, Individual #77, and Individual #70; o For Section S.3, Dental and/or Medical SAPs and corresponding raw data sheets for September, October, and November 2013, as available, for: Individual #103, Individual #6, Individual #79, Individual #175, Individual #8, Individual #47, Individual #299, and Individual #119; and o Completed Skill Acquisition Treatment Integrity Forms, as provided following direct observation during onsite visits, for: Individual #137 and Individual #3. ▪ **Interviews with**: o Jim Forbes, Director of Behavioral Services, and Carolyn Milton, Assistant Director of Behavioral Services, on 1/6/14 and 1/7/14; o Tracey Snow-Murphy, Director of Residential Services, on 1/7/14; o Mary Ortiz, Director of Competency Training and Development, on 1/8/14; o Stephanie Brasfield and Denise Johnson, Unit Directors, on 1/8/14; o Laura Anciso, Director of Vocational and Day Programs, and Rosie Driver, Supportive Employment Coordinator, on 1/9/14; o Sandi Kennedy, QIDP Coordinator, Section F meeting, on 1/9/14; o Marty Sosa, Integrated Program Developer (IPD), and Elizabeth Elise, Integrated Program Developer, on 1/9/14;

	○ Raul Jaime Trevino, QA Program Compliance Monitor (Section K), and Marilyn Foster, QA Program Compliance Monitor (Section S), on 1/10/14; and ○ Rodshadi Moore, Active Treatment Supervisor, as well as Active Treatment Coordinators Kimmie Scott-McGruder, Robbie Walker, Channing Robinson, and Brylon Bradford, on 1/10/14. ▪ **Observations Conducted**: ○ Specialize Class Meeting, on 1/7/14; ○ SAP Competency Integrity Check at the Small Workshop, on 1/7/14; ○ SAP Competency Integrity Check at Maple (517), on 1/7/14; ○ PBSP competency-based training at Oak (518), on 1/8/14; ○ IOA data collection at Elm (515), on 1/8/14; ○ IOA data collection at the Small Workshop, on 1/8/14; ○ Behavior Support Committee Peer Review Meeting, on 1/9/14; ○ Desensitization Committee Meeting, on 1/9/14; ○ Onsite direct observation and/or interaction with direct support professionals, and other professionals were conducted throughout the morning, afternoon, and/or evening hours at the following sites: ▪ Aspen (513), on 1/6/14; ▪ Oak (518), on 1/6/14 and 1/7/14; ▪ Willow (520), on 1/6/14; ▪ Small Workshop, on 1/7/14 and 1/8/14; ▪ Elm (515), on 1/7/14; ▪ Maple (517), on 1/7/14; ▪ Birch (514), on 1/7/14; ▪ Fir (516), on 1/7/14; ▪ Canna (521), on 1/7/14; ▪ Rose (525), on 1/8/14; ▪ Violet (523), on 1/8/14; ▪ Iris (527), on 1/9/14; and ▪ Zinnia (528), on 1/9/14.
	Facility Self-Assessment: Lubbock State Supported Living Center submitted a Self-Assessment for Section S, dated 12/20/13. In the Self-Assessment, for each subsection, the Facility identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The Self-Assessment indicated that the Facility was not in substantial compliance with any of the three provisions in Section S of the Settlement Agreement. This finding was consistent with the Monitoring Team's current findings. Based on a review of the Facility Self-Assessment for Section S, the monitoring/audit templates (including instructions/guidelines, when available), a sample of completed monitoring/auditing tools, and interviews with staff: ▪ The monitoring/audit tool the Program Compliance Monitor used in the past included the "Section

	S – Habilitation, Training, Education, and Skill Acquisition Programs" (Revised August 2010). The PCM continued to utilize this rubric, concurrent with its completion by Integrated Program Developers, on a monthly basis (i.e., four samples per month). This appeared consistent with the process that was previously in place. Reports indicated that this rubric was recently slightly revised (in November) to facilitate better compliance and agreement. Based on summary documentation (i.e., monthly Department and QA meeting notes, QA/QI Quarterly Summaries) and provided samples, it appeared that the Section S monitoring tool, including efforts to estimate inter-rater reliability, were completed in July, August, September, and October. Although total compliance scores were reported in provided documentation for May and June, total compliance scores were not reported for the months following the Monitoring Team's previous visit. It should be noted, however, that compliance percentages were illustrated (on graphs) for select items on the monitoring tool each month. In addition, inter-rater reliability estimates were generated each month. These included averages of 56% (July), 67% (August), 87% (September), 91% (October), and 94% (November). According to reports, it appeared that the lower estimates were related to multiple changes within the PCM position. ▪ In general, the prescribed self-assessment process the PCM completed monthly appeared to include the random selection of four individuals from the ISP schedule. Once identified, the PCM and IPD would concurrently and independently complete a Section S monitoring tool. Instructions on how to complete the monitoring were integrated within the monitoring tool. Once completed, the two raters examined the scored monitoring tools and generated inter-rater reliability estimates. ▪ Reports also indicated that, in addition to checks the PCM completed utilizing the Section S monitoring tool (as described above), a second PCM also completed monthly checks of the quality of skill acquisition programs using the "Skill Acquisition Program Quality Assurance Tool." More specifically, it was reported that the PCM selected four recently completed SAPs written by each of the four IPDs and both the PCM and IPDs subsequently scored them for quality. Consequently, each month, the PCM reviewed a total of 16 SAPs for quality (i.e., including the concurrent review of four SAPs by each IDP). Generated quality scores as well as inter-rater agreement scores were not provided. ▪ The self-assessment process also appeared to prescribe monthly meetings in which the PCM and IPD discussed on-going monitoring. Provided documentation reflected meetings in July, August, September, October, and November, and meeting minutes reflected an active monitoring process including discussion of specific individual reviews, sample size, identified strengths, needed areas of improvement, and other issues. Inter-rater reliability estimates of completed Section S monitoring tools were provided for each month. ▪ The self-assessment process also included examination of active treatment, including estimates of engagement, through the completion of the "Consumer Support Observation and Interview" rubric the PCM completed. This tool appeared to be completed monthly and included engagement estimates as well as estimates of staff knowledge, interactional style, active treatment, and skill acquisition programs for six selected individuals based on direct observation and interview. Data on the use of this rubric was summarized monthly across six categories (i.e., engagement, tone of voice, choices offered, independence, privacy, and personal appearance) for each individual

	selected. Inter-rater reliability estimates did not appear to be generated when using this rubric. ▪ Beyond the efforts of the PCMs (as described above), the self-assessment process also utilized other relevant data sources and/or indicators/outcome measures as examined by the Director of Residential Services, Unit Directors, IPDs, and active treatment staff. For example, the current self-assessment contained reference to several processes and tools, including review of active records, use of the skill acquisition treatment integrity monitoring form, the skill acquisition program quality assurance tool, active treatment engagement monitoring forms, vocational services assessment grading tool, PSI quality measure grading tool, and the 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). ▪ As presented above, the Facility used relevant data sources and/or was using some key indicators/outcome measures and, in general, presented data in a meaningful/useful way. However, the Facility did not provide inter-rater reliability estimates on several of the key indicators (e.g., SAP quality tool, consumer support observation and interview, engagement monitoring form, FSA quality assessment, etc.).
	Summary of Monitor's Assessment: Continued efforts to support the development of quality SAPs were noted. This included stronger support for SAP developers from the State Office, the revision of the SAP development curriculum and the quality assessment tool, and improved ongoing monitoring of SAP quality. However, concerns remained regarding the quality of SAPs, including those targeting dental and medical desensitization as well as ongoing data collection, monitoring, and review. Overall, the SAPs reviewed, data collection methods, and ongoing monitoring continued to demonstrate the need for substantial improvement. Estimates of engagement were improved compared to previously estimated levels. Concerns remained with regard to QA and active treatment staff continuing to estimate engagement using two different tools, as well as with the implementation of the SAP Integrity Monitoring Tool. Overall, slight improvement in providing opportunities for community outings were noted. Efforts directed at supporting day and vocational programming, including attendance, were noted. However, efforts at improving attendance at day program as well as on-campus and community-based employment had not yet evidenced substantial progress. Efforts directed at improving tools to ensure the adequacy of annual assessments (e.g., the PSI and FSA) were noted. However, concerns were noted with regard to initial attempts to develop the FSA Quality Measure Grading Tool, as well as the lack of inter-rater reliability across all quality assessments. Overall, concerns regarding the adequacy of completed PSIs and FSAs remained.

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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.	In an effort to examine the quality of current Skill Acquisition Programs, a sample of 16 individuals who had an Individual Support Plan meeting over the past six months was selected and their SAPs were requested for review. Overall, it appeared that a total of 60 Skill Acquisition Programs were developed for these individuals. Of these, it appeared that approximately four (range of one to six) SAPs were developed, on average, for each individual sampled. In addition, it appeared that 59 (98%) of the SAPs were completed using the most recent SAP format. The exception was a SAP for Individual #240 (i.e., eyeglass care). In an effort to more closely examine the quality of current skill plans, one SAP was randomly selected and reviewed for each individual in the sample who had SAP data (for at least one month) currently available for review. Consequently, this smaller sub-sample included 12 individuals and selected SAPs are identified below. In addition to the examination of each SAP, available ISPs, Functional Skills Assessments, Preferences and Strengths Inventory, Monthly Reviews, and SAP data sheets, for the last three months, as provided, were reviewed and were the basis of the subsequent findings. The following SAPs were included in the sample: ▪ The SAP for Individual #65 targeting communication at work; ▪ The SAP for Individual #109 targeting choice making; ▪ The SAP for Individual #111 targeting hand washing; ▪ The SAP for Individual #170 targeting tooth brushing; ▪ The SAP for Individual #140 targeting communication; ▪ The SAP for Individual #40 targeting making change; ▪ The SAP for Individual #87 targeting on-task behavior at work; ▪ The SAP for Individual #308 targeting flossing; ▪ The SAP for Individual #97 targeting object cues; ▪ The SAP for Individual #139 targeting communication; ▪ The SAP for Individual #3 targeting using hand sanitizer; and, ▪ The SAP for Individual #240 targeting medication identification. The selected SAPs 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 assessments. All of the SAPs included a rationale section with many referencing one or more assessments, recommendations of direct support professionals, and/or IDT discussion at ISP meetings. It is important to remember that discussions at ISP meetings with various professionals, including direct support professionals does not equate to identification of needs through the completion of formal assessment(s). Currently, of the 12 SAPs reviewed, it appeared that 10 (83%) identified one or more assessments as the basis of the targeted need. The exceptions were SAPs with rationales that only listed the IDT discussion at the ISP (i.e., Individual #40 and Individual #3). Of the remaining 10 SAPs, three (30%) appeared based on the findings of one or more of those assessments (i.e., Individual #65, Individual #109, and Individual #140). The exceptions included three (30%) SAPs that identified assessments (i.e., dental, speech, psychological, and/or	Noncompliance

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		medical) that were unavailable for review and, consequently, could not be confirmed (i.e., Individual #170, Individual #308, and Individual #139), and three (30%) SAPs that listed the FSA or Vocational assessment as the basis of the SAP when, based on the Monitoring Team's review, it appeared that the assessment did not conspicuously recommend the identified need to be targeted through a formal SAP (i.e., Individual #87, Individual #97, and Individual #240). In addition, two of the assessments (PSI and FSA) completed for Individual #111 appeared to offer contradictory findings regarding the need of the targeted skill. Overall, of the 12 SAPs reviewed, it appeared that only three (25%) were based on and specifically targeted by assessments. However, 12 (100%) of the SAPs appeared to be discussed by the IDT as evidenced by content documented within the ISP and/or listed in action plans outlined within the ISP. Overall, it continued to be a challenge to determine if the needs the SAPs targeted were based on scored items within the assessments and/or recommendations within completed assessments. For example, in one case, completed assessments appeared contradictory with regard to the identified need (e.g., the PSI and FSA appeared inconsistent with regard to hand washing skills for Individual #111). In addition, some findings of assessments and/or discussions of the IDT appeared to be overlooked based on the developed SAP. For example, the vocational assessment for Individual #109 repeatedly highlighted the need for staff to use the communication dictionary. However, the SAP targeting choice making did not mention the use of the communication dictionary at all. In addition, the vocational assessments and IDT discussion for Individual #65 appeared to recommended two related SAPs, but only one was actually implemented. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that SAPs be conspicuously based on and consistent with completed assessments. Upon review of the 12 sampled SAPs, it was noted that 12 (100%) were completed using the most current SAP format. In an effort to provide a comprehensive review of the most current SAPs, these 12 SAPs were reviewed and the following was observed: ▪ One (8%) had an adequate behavioral objective. This included Individual #140 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 many SAPs, given the inadequacy of their task analysis, did 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	

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		definition of the target response(s) was also viewed as inadequate; ▪ Ten (83%) had an adequate description of necessary materials. Those SAPs with inadequate information about materials included those for Individual #109 and Individual #87; ▪ Twelve (100%) had an adequate description of the setting/environment; ▪ Five (42%) had sufficient opportunities for learning to occur (i.e., adequate schedule of implementation). This finding may underestimate actual opportunity as, given the descriptions, the Monitoring Team could assume that opportunities for trials were likely daily for the majority of individuals. However, the vague descriptions [e.g., "when he showers" (Individual #97), "during every interaction" (Individual #139), "each med pass" (Individual #240), "both shifts, if necessary" (Individual #308), "each time at workshop" (Individual #140), "toothbrushing times" (Individual #170)] found in the SAPs for did not appear to provide sufficient specificity to adequately implement the SAPs; ▪ Twelve (100%) included discriminative stimuli. However, concerns were noted with the discriminative stimuli used in five SAPs (i.e., for Individual #165, Individual #109, Individual #111, Individual #139, and Individual #240) and are discussed below; ▪ Twelve (100%) conspicuously identified the type of chaining (i.e., forward, backward, or total task) utilized in the SAP. However, concerns were noted as described below; ▪ Eight (67%) identified the instructional strategy (e.g., least-to-most). The exceptions included those for Individual #111, Individual #40, Individual #139, and Individual #3; ▪ Five (42%) provided adequate descriptions/definitions of the types of prompts found within the listed prompt hierarchy. These included the SAPs for Individual #109, Individual #140, Individual #87, Individual #139, and Individual #240. The exceptions included SAPs that were incomplete, unclear, and/or incompatible to the skills being taught; ▪ Although 12 (100%) identified an initial prompt level, only eight (67%) indicated a criterion of when to change to a less (or more) intrusive prompt level, if necessary. The exceptions included those for Individual #140, Individual #40, Individual #87, and Individual #3; ▪ Of the eight SAPs that utilized forward chaining, only four (50%) had instructions on when to change to a different step. These included the SAPs for Individual #308, Individual #139, Individual #3, and Individual #240. However, all of the instructions provided appeared inadequate; ▪ Twelve (100%) described specific consequences for correct responding. However, concerns were noted as described below; ▪ Twelve (100%) described specific consequence for incorrect responding. However, concerns were noted as described below;	

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		▪ Twelve (100%) identified the use of reinforcement following correct responding. However, only three (25%) utilized individualized reinforcers other than social praise (i.e., Individual #170, Individual #308, and Individual #3); ▪ Twelve (100%) described plans for generalization and maintenance. However, concerns with the lack of specificity and likely delayed implementation (of generalization strategies) were noted (described below); and ▪ Twelve (100%) contained data collection instructions. However, only five (42%) appeared to prescribe sufficient data collection. These included SAPs requiring data collected three or more times per week (i.e., Individual #170, Individual #111, Individual #40, Individual #139, and Individual #3), and none (0%) provided sufficient detail to ensure adequate completion of data sheets. An additional sample of medical and dental desensitization SAPs was reviewed to determine their quality. This review was similar to that completed for the SAPs as identified above and was based on a sample the Facility identified as the "… most recently developed and appropriate medical or dental desensitization plans" (TX-LB-1401-II.17, dated 11/22/13). Of these, a sample was selected and included a total of six SAPs, including four targeting dental desensitization (i.e., Individual #258, Individual #217, Individual #232, and Individual #274) as well as two that were identified as targeting both medical and dental desensitization (i.e., Individual #276 and Individual #109). Of the six desensitization SAPs reviewed, the following was observed: ▪ Zero (0%) had adequate behavioral objectives; ▪ Zero (0%) appeared to have an adequate task analysis; ▪ Six (100%) had an adequate description of necessary materials; ▪ Six (100%) had an adequate description of the setting/environment; ▪ Two (33%) had sufficient opportunities for learning to occur. The exceptions were SAPs that provided vague references to when the skill should be practiced (i.e., Individual #276, Individual #109, Individual #232, and Individual #274); ▪ 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 utilized in the SAP. However, none (0%) included instructions on when to move to the next step (i.e., when the step was mastered) when using forward chaining; ▪ Two (33%) appeared to provide adequate descriptions for all of the prompts within the listed prompt hierarchy. These included Individual #276 and Individual #232; ▪ Although six (100%) identified an initial prompt level, only four (67%) identified the instructional strategy (e.g., least-to-most or most-to-least) and four (67%) identified the criteria necessary to increase or fade the prompt level;	

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		▪ Two (33%) appeared to limit unnecessary prompts following an incorrect response (i.e., Individual #258 and Individual #217); ▪ Six (100%) described specific consequences for correct responding. However, only three (50%) included the use of individualized reinforcers (i.e., a preferred stimulus other than social praise); ▪ Six (100%) described specific consequence for incorrect responding. However, these only highlighted the use of differential reinforcement and did not direct staff to begin error correction as prescribed; ▪ Zero (0%) identified adequate plans for generalization and maintenance. It should be noted that all of the SAPs included descriptions for generalization and maintenance, but all of the sections lacked specificity; ▪ Six (100%) contained special instructions that appeared relevant; ▪ Six (100%) contained instructions for data collection. However, only two (33%) provided adequate specificity regarding when to run trials (i.e., Individual #258 and Individual #217), and none (0%) described when and how to record a correct (+) or incorrect (-) response; ▪ Two (33%) appeared to include a sufficient number of trials to support effective acquisition (i.e., Individual #258 and Individual #217); ▪ Four (67%) appeared to prescribe a sufficient frequency for data collection. The exceptions included #217 and Individual #232; 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. It should be noted that several of these SAP appeared to target skills that were necessary pre-requisites for successful medical and dental procedures, as well as skills that would likely promote good health. However, several of the SAPs did not appear as relevant to promoting medical or dental desensitization (e.g., a shaving program for Individual #109 and an appointment scheduling program for Individual #276). Overall, it continued to be unlikely that the majority of SAPs, including dental and medical desensitization programs, were currently promoting growth, development, and independence across most individuals served at LBSSLC. Overall, the reviewed SAPs continued to demonstrate the need for substantial improvement. It should be noted that the concerns reported here are similar to ones identified and described within previous reports. Consequently, the review here is brief and reviews many of the same findings detailed in the Monitoring Team's previous report. For more detailed feedback, the Facility is encouraged to review Monitoring Team's previous reports. Examples of concerns are noted below: ▪ Discriminative stimuli appeared to include only verbal responses from staff, and,	

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		at times, included additional, seemingly unnecessary and/or unrelated 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. ▪ Behavioral objectives were inadequate. That is, many provided vague references to a target behavior (e.g., "…will allow," "...independently allow," "…will independently respond," or "…will stay on task") that were not adequately defined, especially when the corresponding task analysis was inadequate. 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. The purpose of a task analysis is to break a complex skill or a series of behavior into smaller, teachable units. Consequently, developers of SAPs should reconsider the usefulness of a task analysis when only a single response (or step) has been identified. ▪ Task analyses continued to be designed to shape a single dimension of behavior (e.g., duration) and not designed in an effort to chain together a sequence of discrete responses aimed at a complex skill. Designers may want to reconsider using a different, less rigorous and perhaps more efficient methodology (e.g., a simple shaping program might be more appropriate). ▪ Descriptions used to define the type of prompts within the prompting hierarchy were often inadequate or missing. The Facility should consider standardizing how the prompts within the typical hierarchy are defined. These should include only descriptions of staff responses. ▪ The special instructions section should be used to highlight atypical issues (e.g., if someone is blind), and include implications or information specifically related to how staff should (or not) respond; ▪ Repeated use of the same prompt level following an incorrect response was found in the majority of SAPs. It was unclear why a typical prompting sequence (e.g., most-to-least or least-to-most) would not be used following an incorrect response(s). The Facility should consider the potential negative consequences (e.g., prompt dependency, increased likelihood of incorrect responding, etc.) associated with this continued practice. ▪ The Facility should consider that utilizing primarily social praise [i.e., as the only form of (potential) positive reinforcement] in the majority of SAPs might not be sufficient. Indeed, social praise is a secondary or conditioned reinforcer, and might not prove to be an effective reinforcer in some cases. ▪ Error correction instructions continued to place an emphasis on limiting inadvertent social reinforcement. However, subsequent detail with regard to	

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		error correction procedures continued to be lacking in many SAPs. Detailed instructions describing staff responding following an incorrect trial needs to be consistently included in all SAPs. This should include guidance on how to prompt correct responding relative to the identified instructional strategy. ▪ When using forward or backward chaining, criteria of when to change to a new step is required. In the current review, criteria were only found in half of the SAPs that used forward chaining, and, in all cases, the criterion was vague. Specific objective measurable criteria need to be identified to inform staff when to move on to training the next step of the task analysis. ▪ More description related to generalization and maintenance should be included in SAPs. This should include specific plans to conduct generalization trials before and after the skill is acquired under variable stimulus conditions. Currently, generalization was only prescribed after the individual had mastered the skill. 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 include more comprehensive and helpful descriptions related to generalization and maintenance. ▪ A criterion for review should be identified in each SAP, if limited or no progress was noted. ▪ In general, all SAPs should be closely reviewed and/or edited, because content provided throughout some plans was inaccurate or did not make sense. For example, the content in the hand washing SAP for Individual #111 included several references to teeth brushing. Overall, concerns remained with regard to development of quality SAPs. Indeed, the concerns noted here were consistent with those noted in the Monitoring Team's past reports. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that SAPs contain critical elements as highlighted above. As noted in the Monitoring Team's previous report, Integrated Program Developers had been hired to write the majority of SAPs and, since the Monitoring Team's last visit, reports revealed turnover in several of these positions. However, at the time of the current onsite visit, four IPDs were in place and reports indicated that their responsibilities had remained the same. Behavior Health Specialists and Behavior Analysts continued to share responsibility for writing SAPs that targeted replacement behaviors, counseling SAPs, and more complex dental or medical desensitization programs. Integrated Program Developers also attended ISP Preparation meetings and annual ISP meetings, as well as trained staff members (e.g., Home Team Leaders, Residential Coordinators) who assisted with training direct support professionals. In addition, they tracked the development of SAPs, as well as monitored procedural	

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		integrity of SAPs (i.e., integrity checks are discussed with regard to Section S.3.a of the Settlement Agreement). The curriculum used to develop SAPs (i.e., Skill Acquisition Plan - Instructions for SAP Development, revised 5/22/13) was previously reviewed, and, at the time of the Monitoring Team's previous review, it was noted that the curriculum provided an overview of the ISP process as well as specific guidance in developing adequate SAPs. It also was noted that the curriculum was inadequate in several areas, and recommendations were offered in the last report in an effort to improve the quality of the SAPs. Based on findings from the recent review of sampled SAPs, as reported with regard to Section S.1 of the Settlement Agreement, many of these recommendations regarding the development of SAPs continued to appear relevant. Consequently, the Facility is encouraged to review the recommendations related to SAP development provided in the Monitoring Team's previous and current reports, as well as the current curriculum and determine if further revision is necessary. Current verbal reports and provided documentation indicated that the Active Treatment Supervisor and IPDs recently had revised the curriculum (on 10/28/12 and 11/15/13). However, it was clear to the Monitoring Team that revision of the curriculum was still necessary with regard to content targeting "Essential Elements of a SAP," including, for example, the skill objective, specific actions for correct/incorrect responding, generalization, maintenance, training steps/task analysis, teaching methods, and prompting. Overall, the current descriptions appeared to need greater specificity, including the use of more detailed examples relative to each essential element. Verbal reports also indicated that in October 2013, Facility staff, including IPDs and other Active Treatment Staff attended a three-day conference in Austin. This State Office sponsored training targeted active treatment, including the development of quality SAPs. Subsequent statewide scan calls also were utilized to continue discussion and promote progress after the conference. Feedback from attendees was positive and appeared to reflect a more robust and systemic State Office focus on issues related to habilitation, training, and skill acquisition. This recent, although delayed, emphasis on Section S by the State Office was well received by the Monitoring Team. Going forward, the Monitoring Team encourages the State Office to continue this heightened level of oversight and support, which was greatly needed to ensure improvements in quality of services as well as systematic and enduring change. It should be noted that verbal reports from IPDs indicated a preference by attendees of the workgroup toward selecting the LBSSLC SAP format as one of the potential formats likely recommended for use in Facilities across the state. While this recognition was indeed a compliment to the hard work and progress the Facility had made (i.e., the Monitoring Team acknowledges and commends these efforts as well), the Monitoring Team strongly cautions the Facility and State Office to recognize that the current SAP format, including related data sheets	

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		and monthly progress note formats, continued to require additional revision and improvement. In addition to attendance at the conference, IPDs also met briefly with two professionals (with backgrounds in special education and behavior analysis) from the Lubbock Independent School District for supplemental consultation regarding skill acquisition programming and the development of quality SAPs. According to verbal reports, these opportunities for consultation appeared helpful. It was suggested that the IPDs might arrange future opportunities for further consultation with these specialists. As presented in the Monitoring Team's previous report, IPDs utilized the SAP Quality Assessment Tool in an effort to ensure the quality of SAPs. As detailed in the Monitoring Team's previous report, concerns were noted with regard to the adequacy of this tool (i.e., too few items, inconsistent with the SAP format), as well as how it was utilized (i.e., too few probes completed, lack of inter-rater reliability estimates across raters). Since the Monitoring Team's last visit, it appeared that this tool had been revised significantly. That is, the new rubric, entitled the "Skill Acquisition Program Quality Assurance Tool" or "SAP QA Tool/Rubric" had been developed and appeared to include many more items (50 questions), and was formatted similarly to the SAP. Overall, it appeared to be a much more comprehensive tool and a substantial improvement over the previous SAP quality assessment. Data provided within the Section S Self-Assessment appeared to reflect estimates of quality based on samples of SAPs (n=112) collected between May and November 2013. However, the majority of these scores were produced through the use of the previous tool, and, according to the Director of Residential Services, estimation of inter-rater reliability (using item analysis) was just recently initiated (although not reported). Findings from additional similar reviews of sampled SAPs also were provided in the Section S Self-Assessment. More specifically, these reviews included smaller samples of SAPs targeting dental/medical desensitization (n=10), PBSP replacement behavior (n=6), and communication (n=13). Verbal reports indicated that the new SAP QA tool was used to evaluate quality in these samples. However, inter-rater reliability was not reported. Overall, reported scores appeared variable with most estimates above 80%. However, lower quality estimates were reported for the PBSP replacement behavior SAPs. Consequently, at the next review, the Monitoring Team will review both QA staff and IPDs' efforts in utilizing this tool to ensure quality, including inter-rater agreement. Provided documentation evidenced the development of a monitoring system (database) that tracked monthly completion of SAP Quality Rubrics. That is, documentation revealed that between May and October 2013, each IDP completed four SAP Quality Rubrics every month. For November, additional total quality scores for each SAP were provided following the QA staff's review. For each month, it appeared that a total score	

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		was provided for each SAP completed by each IDP. However, the specific rubric utilized as well as estimates of inter-rater reliability were not provided. The Monitoring Team recognized the Facility's recent efforts at improving skill acquisition programming, including participation in the State Office sponsored conference, consultation with local educational professionals, as well as revision of the SAP development curriculum and the development of the more comprehensive SAP QA Rubric. And, as indicated in previous reports, the Monitoring Team continues to recognize that many of the recommendations and related changes would take time to translate into practice. Consequently, it is expected that corresponding changes in actual SAPs will be increasingly evident over time and the Monitoring Team looks forward to examining related progress during the next monitoring visit. 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, painting, manipulating musical instruments, etc.) and passive forms (e.g., listening to the radio, watching TV, etc.) of engagement. The table below provides specific information on observed level of engagement (i.e., number of individuals engaged to total number of individuals) in relation to staff-to-individual ratios across program sites. Engagement and Staffing Ratio Observations ***Location*** / ***Engaged*** / ***Staff-to-individual ratio*** Aspen / 2:3 / 1:3 / 2:2 / 1:2 Willow / 4:4 / 2:4 / 1:2 / 0:2 / 0:1 / 0:1 Oak / 1:1 / 2:1 / 2:4 / 2:4 Birch / 1:1 / 2:1 Elm / 4:4 / 2:4 / 2:3 / 0:3 Fir / 1:1 / 1:1 Maple / 0:2 / 0:2	

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	2:6	1:6
	3:6	3:6
Canna	0:1	0:1
	2:3	1:3
Rose	3:3	2:3
Violet	3:3	3:3
	2:3	2:3
Zinnia	3:6	2:6
Iris	3:3	2:3
	4:5	2:5

Based on data collected during brief residential visits, overall engagement was 67%. This reflected improvement in the estimated level of engagement compared to the previously estimated level (56%) 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 Monitoring Team's previous 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 detailed in the Monitoring Team's previous report, the Active Treatment Department had been utilizing the "Engagement Monitoring Form" (revised 3/13/12) to estimate the competency of staff to promote active engagement (Part I) as well as to estimate individual engagement (Part II). Raters scored items on Part I based on verbal reports and direct observation and calculated an overall staff competence score. Raters scored items on Part II based only upon direct observation and calculated an overall engagement score. In March 2013, the Facility revised the form to target whether or not daily activity schedules were followed. As reported in the Monitoring Team's previous report, monthly scores, as provided for September 2012 through June 2013, evidenced highly variable levels of engagement. As noted then, engagement estimates were not provided for three months (i.e., December, April, and June). The lack of data in April and June was due to the emphasis placed on training and implementing the new activity schedules developed in collaboration with an external consulting firm. Overall, of the estimates provided at that time, engagement estimates from only three months reflected scores over 75%.

Summary data included within the most recent Section S Presentation Book reflected engagement estimates of 71%, [not reported], 73%, 82%, 89%, and 89% for May, June, July, August, September, and October, respectively, as reported by Active Treatment Staff.

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		Data provided within Section S.1 of the Self-Assessment reflected engagement estimates of 75%, [not reported], 76%, 82%, 90%, 90%, and 90% for May, June, July, August, September, October, and November 2013, respectively. It was noted that, although close, four of these scores did not correspond across documents the Facility provided. Nonetheless, overall, these engagement scores demonstrated an improvement compared to those previously reported and reflected increasing trends across residences and programs over time. In addition, although not reported in the Self-Assessment, competency scores also appeared to improve. More specifically, based on data provided within the Engagement Monitoring spreadsheet, competency scores of 78%, 84%, 92%, and 93% were reported for July, August, September, and October, respectively. Summary data provided in the Section S Self-Assessment also evidenced similar engagement estimates reported by QA staff. That is, engagement estimates generated by QA staff were similar to, if not higher, (i.e., ranged from 93% to 100%) to scores Active Treatment staff generated during the same time period. It should be noted, however, that QA and Active Treatment Staff utilized different rubrics when estimating engagement. This discrepancy had been noted in the Monitoring Team's last two reports and, currently, had not yet been resolved. Consequently, it was unclear if provided inter-rater reliability scores were based on the inappropriate comparison of ratings generated by QA and Active Treatment Staff, or through the appropriate comparison of two Active Treatment raters. Based on provided documentation, the Facility had created a database to track when and where engagement forms were completed. More specifically, data on the residence/program, shift, number of staff, number of individuals, and the rater were populated within the database, along with corresponding scores on each item, as well as overall competence and engagement scores. Consequently, an efficient system had been developed to track not only the scores on each completed form, but also other relevant information as well. However, it was noted that only two (or less, for programs) engagement estimates were generated for each residence per month. Given the inadequacies observed in maintaining adequate levels of engagement in the Monitoring Team's previous reports, the small number of required monthly probes in each setting appeared insufficient. This situation was even more concerning given the amount of missing engagement data noted some months. More specifically, closer examination of the spreadsheet revealed that 29%, 29%, 6%, 20%, and 26% of engagement data from May, July, August, September, and October, respectively, was missing. In addition, inter-rater reliability estimates were not yet generated. In the end, the Monitoring Team viewed the development of this database as an improvement, and believed that it reflected necessary progress toward adequately tracking and monitoring engagement across campus. The Facility should consider the above concerns when revising the database in the future.	

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		According to verbal reports and provided documentation, since the Monitoring Team's last visit, the Active Treatment Supervisor and the IPDs had collaborated on recent revisions within the SAP training curriculum used to train direct support professionals and other program staff. This revision was completed in November 2013. Evidence of completed trainings by the Active Treatment Supervisor, including attendance rosters as well as an active employee course participation report, was provided within the Section S Presentation Book. It reflected six trainings on active engagement/treatment training between May and November 2013. These trainings appeared substantial in content (four to eight hours in duration), and included approximately 126 trainees. In addition to revisions to the SAP curriculum, a new test (Skill Acquisition Test) was developed for new hires following NEO training. According to provided data, this test had been utilized since May and scores reflected that approximately 56% and 44% of new hires passed the test on the first and second try, respectively. Overall, this test was quite brief (only seven items), but it was a good initial attempt at designing a test to assess whether or not new hires understood the training. The Facility might wish to consider having new hires practice with each other on implementing a simple SAP, and then grade them on their implementation of the SAP using the integrity monitoring form. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to 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 previously identified, and the degree of changes in these materials was unclear to the Monitoring Team. Consequently, the Facility is encouraged to review the Monitoring Team's previous and current feedback regarding ways to improve the quality of SAP development, training, and ongoing monitoring. As detailed in the Monitoring Team's previous report, the Facility had worked to improve active treatment through the use of out-of-home and in-home group activity schedules, 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. As noted at that time, external consultants initially facilitated the implementation of these supports, but Active Treatment Coordinators continued to work to maintain these supports in an effort to promote active treatment. Recently, in October 2013, the Facility created a system to monitor and track the completion and posting of activity schedules within each home. As set up, each month, the Active Treatment Supervisor checked each residence to determine if the activity schedules were adequately completed as well as posted. According to provided data, monthly checks reflected 100% for October and November for adequate completion and posting. These efforts might have played a role in the increasing engagement rates	

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		as estimated by QA and Active Treatment Staff over the past six months (as described above). However, the Facility would need to complete further analysis to determine if these efforts were functionally related. Based on informal observations by a member of the Monitoring Team during residential site visits, it appeared that these materials (e.g., group activity schedules, daily objective schedules, and individualized data cards) were readily available in most homes. However, there were a few residences where the materials were not conspicuously available. The Monitoring Team's previous reports examined several data sets related to the number of individuals supported within on-campus day and vocational programs, on-campus workshop, client worker and enterprise programs, as well as off-campus enclave settings, and off-campus supportive and competitive employment. Indeed, data presented in the Monitoring Team's last report specifically detailed changes in available opportunities over time. At that time, provided data reflected mixed results. That is, the majority of data reflected either a recent decline or no progress at all. More specifically, although improvement was noted in previous years, more recent data reflected significant decreases in individuals served in the vocational, workshop, client worker, and enterprise settings. Total numbers of individuals attending day programs off their homes also decreased and data reflected no substantial change in the number of individuals in part-time on- and off-campus work, as well as in individuals hired to work in competitive employment settings. Lastly, as noted in the previous report, supportive employment positions had been slowly diminishing as well. Currently, available data displayed within the Vocational/Day Program summary (May to December 2013), provided to the Monitoring Team at the time of the onsite visit, did not evidence any significant changes in any of the positions described since the Monitoring Team's last visit (i.e., data from January through June 2013). It should be noted that data on the number of individuals served in part-time on- and off-campus employment, as well as individuals placed in on-campus, off-home day programs was not provided. Overall, based on data that was provided, no significant changes were noted in the number of individuals served in the on-campus workshop, off-campus supported part-time work, or off-campus supported employment settings. Only very slight improvement was noted in the number of individuals served within the on-campus client worker program (i.e., two workers were added) and within off-campus competitive employment (i.e., two workers were added). The Facility acknowledged the lack of significant improvement and the stability in scores over the past six months (i.e., reflective of no loss of work) as stated in Section S.3.b of the Self-Assessment. The Facility indicated that the recent purchase of a new cardboard bailer (in October 2013) was likely to increase work opportunities for more individuals. In addition, ongoing efforts to expand opportunities for crafting and woodworking (producing new	

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		products) at Estacado Industries Workshop and food service jobs, including delivery services and expanded hours, at the Diner were likely to increase work opportunities for more individuals as well. Vocational and day program staff members continued to collaborate closely with an assigned Behavior Analyst to ameliorate behavioral issues that limited individuals' involvement with work or program attendance and/or participation. Currently, data displayed within the provided Vocational/Day Program summary also illustrated data on attendance rates. This data included attendance percentages for individuals attending day and vocational programs each month from September 2012 through November 2013. With the exception one of dramatic decrease in February 2013, attendance data remained relatively stable for both programs. More specifically, the percent of individuals attending day or vocational programs averaged (and ranged) 67% (42% to 73%) and 86% (63 to 92%) per month, respectively. The reason for the significant and an atypical drop in attendance across both vocational and day programs in February 2013 was unknown to the Monitoring Team. It should be noted that reviewing vocational data continued to be challenging for the Monitoring Team, because the Facility continued to change how job descriptions were defined and/or categorized. Indeed, some provided data were not included in the current review (e.g., community outreach data), because it appeared to be inconsistent with data provided during the Monitoring Team's previous review. Consistent definitions and/or categories would facilitate efficient monitoring and/or interpretation of performance over time. Discussions with the Facility reflected willingness and recent efforts at improving data management and ongoing monitoring. 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. These efforts included the continuation of two committees, including the Attendance Committee and the Community Outreach Committee. As previously described, the attendance committee worked to improve attendance at both vocational and day programs by tracking attendance and working with IDTs to overcome identified barriers (e.g., medical issues, etc.). Current verbal reports and provided documentation indicated that this committee was still active in facilitating improved attendance. As noted above, documentation evidenced that, since the Monitoring Team's last visit, attendance rates at both vocational and day programs remained relatively stable. Indeed, since March 2013, rates of attendance at vocational programs had remained relatively high and stable (between 87 to 92%). Rates of attendance at day programs had consistently remained below 76%. The Monitoring Team strongly encourages the Facility to "raise the bar" for attendance at day programs and consider challenging IDTs to provide rationales for any	

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		individual that does not participate for the majority of the day. 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 from job coaches. Provided data indicated that since the Monitoring Team's last visit, the number of contracts with community employers slowly increased, which might ultimately facilitate opportunities for supportive or competitive employment. Data provided in the Section S.3.b of the Self-Assessment indicated that contracts with community employers had increased to 12 in November. Since May 2013, the number of contracts had ranged from four to 10 per month. In addition, the committee hosted a business luncheon for local business leaders to share ideas in how to better "market" individuals currently living at the Facility. Lastly, the committee continued to facilitate participation in local community job fairs and exploration tours. In addition to the two committees described above, a third committee, the Assessment Committee, continued to monitor 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 and/or situation explorations. Provided documentation evidenced that, between September 2012 and December 2013, 279 vocational assessments had been completed. Closer examination revealed an approximate average of 17 (ranging from 11 to 25) assessments completed each month with 95% submitted on time. Data over the past six months (July to December 2013) indicated that, on average, 15 (ranging from 11 to 19) assessments were completed each month with 99% submitted on time. Provided documentation also evidenced that, between September 2012 and December 2013, 69 vocational explorations had been completed. Closer examination revealed an approximate average of four (ranging from zero to nine) assessments completed each month with 88% completed as expected. Data over the past six months (July to December 2013) indicated that, on average, five (ranging from three to nine) assessments were completed each month with 100% completed as expected. As previously presented, in addition to tracking the number and timeliness of vocational assessments completed as well as explorations identified and completed, the Assessment Committee also developed and utilized a system to track the average quality scores of completed vocational assessments across raters. This system had been in place since September 2012. However, it should be noted that the Facility had not yet demonstrated	

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		the reliability of the quality tool. That is, inter-rater reliability estimates had not yet been reported. In addition, the tool used to assess the quality of the vocational assessments was just recently revised. Although provided data from its use with raters reflected high estimates of quality, these were based on a limited number of completed assessments (four in October and four in December across two raters) and inter-rater reliability was not completed (this is discussed with greater detail with regard to Section S.2 of the Settlement Agreement). In the previous report, the Employment Grid/Employment Visions tracking system had been described as a recently developed system to monitor efforts at supporting individuals to obtain their identified employment vision. Data on the use of this tracking system was not provided for review. Consequently, the status of this system and implications for its use was unclear to the Monitoring Team. 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. The Facility remained in noncompliance with this provision. As detailed above, continued work was needed to improve SAPs, increase levels of engagement, and ensure that individuals were provided with day and vocational activities that met their needs and preferences and were in the most integrated settings appropriate to their needs.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	As described in the Monitoring Team's previous report, the Facility used the Preferences and Skills Inventory to facilitate the identification of individual preferences, strengths, goals, programs, and supports, as well as necessary subsequent assessments. As described by the Facility, the PSI was the cornerstone of the Facility's person-centered process. In addition, the Functional Skills Assessment had been implemented to facilitate the examination of a substantial number of skill areas, as well as provide additional information on an individual's preferences, strengths, needs, and barriers to community integration that could be utilized to inform the development of objectives and goals, including targeted skill acquisition programs. In an attempt to estimate the current status of the ISP assessment process, with regard to assessment of individuals' preferences, strengths, skills, needs, and barriers, a sample of individuals who had ISP meetings since the Monitoring Team's last visit was selected. More specifically, a sample of 12 individuals was randomly selected, and assessments, including the ISP, PSI, and FSA, as provided, were examined.	Noncompliance

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		It should be noted that, as described in the Monitoring Team's previous report, previously sampled PSIs had been viewed as inadequate. That is, none of the individuals sampled during the Monitoring Team's previous review had a PSI that was adequately completed and available for use prior to the ISP. At that time, it also was noted that the Facility had developed the PSI Quality Measure Grading Tool to assess and monitor the quality of 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. Data presented in the previous report revealed that this tool was used to review 18 PSIs between November 2012 and May 2013 and 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 that time, the Monitoring Team's impression of the tool was that it was too brief, and that items were too broad and might not allow sufficient specification to identify inadequacies in assessments over time. The Facility was encouraged to consider developing additional items that would allow more specification in examining the quality of completed assessments, as well as to complete inter-rater reliability estimates to ensure its integrity and consistency across raters. Over the past six months, the Facility was responsive to these recommendations, and in August 2013, revised the PSI Quality Measure Grading Tool. More specifically, five additional questions were added to the tool. These included questions targeting whether or not the assessment was filed on time, as well as specific questions targeting whether or not measurable living options, employment, relationships, and leisure goals were specified. And, although these additional questions appeared to improve the comprehensiveness of the review, the new format eliminated an item that actually examined whether or not the listed preferences and strengths (in the summary section) as well as the identified goals (i.e., SAP training objectives) were consistent with answers on actual items within the assessment. Nonetheless, the Facility provided data as evidence that these quality tools were being utilized. According to the data provided, between May and November 2013, a total of 36 PSI Quality Measure Grading Tools were completed. This reflected approximately 90% of those expected to be completed. That is, it appeared that the required number (n=6) of tools was not completed in June (5), July (5), September (4), and November (4). Overall, summary data revealed an average (and range) quality rating of 61% (30 to 90%) for PSIs the Facility sampled. Closer examination of quality scores based only on the newly revised PSI format (i.e., targeting tools completed between September and November 2013) revealed that a total of 14 PSI Quality Measure Grading Tools were completed. This reflected approximately 88% of those expected to be completed. Overall, summary data revealed an average (and range)	

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		quality rating of 48% (30 to 90%) for PSIs the Facility sampled. It appeared that both quality tools estimated lower than acceptable quality ratings, and, given the recent revision, the current tool appeared to produce more conservative scores. Consequently, none of the PSIs the Facility sampled reflected acceptable quality. It should be noted that the Facility did not provide evidence that inter-rater reliability estimates were completed using the new PSI Measure Grading Tool. In addition to revisions noted with regard to the quality tool, in March 2013, the PSI format had been revised as well. The format was changed to allow the identification of preferences and strengths following each completed subsection. Consequently, in addition to their integration within the Summary and Analysis sections (Section II and III), identified preferences and strengths relative to Living Options, Employment, Relationships, Leisure and Independence were recorded at the end of each subsection as well. Given the fact that all of the individuals selected for the current sample had ISPs held after the revision date, all of the PSIs should have been completed in the new format. Of the 12 individuals reviewed, documentation evidenced completion of PSIs for 12 (100%) individuals within the last 12 months. Eleven (92%) appeared to be completed using the most current PSI format (i.e., the exception was Individual #139). According to the recorded "Initial PSI date" as well as signature date, all (100%) of the sampled PSIs were completed 10 days prior to the ISP meeting, but only 10 (83%) were filed at the time of the review (the exceptions included Individual #170 and Individual #97). In general, of the 12 individuals sampled, zero (0%) appeared to be adequately completed. More specifically, Section I and/or II appeared to be adequately completed in the PSIs for seven (58%) individuals. The exceptions included Individual #109, Individual #170, Individual #140, Individual #97, and Individual #139. However, Section III appeared to be adequately completed for none (0%) of the individuals sampled. Indeed, none of the PSIs included measureable goals. In addition, as prescribed by the most current PSI Quality Measure Grading Tool, none (0%) of the sampled PSIs contained a comment area in Section III that specified recommendations for SAP/training objectives. The Monitoring Team's current findings appeared consistent with PSI quality assessment results the Facility reported. That is, the quality of completed PSI assessments continued to be inadequate. As described in the Monitoring Team's previous report, previously sampled FSAs had been viewed as inadequate. That is, none of the individuals sampled during the Monitoring Team's previous review had an adequately completed FSA. At that time, it was noted that the Facility had developed the FSA Quality Measure Grading Tool to monitor the quality of developed FSAs. 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	

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		area contained recommendations for SAPs; and 5) the findings reflected an accurate assessment of the individual. Summary data provided at that time indicated that 36 FSAs had been reviewed and estimates of quality were below 80% (ranged from 20 to 100%) for the majority of FSAs. In addition, data revealed inadequate inter-rater reliability estimates. At that time, the Monitoring Team's impression of the tool was that it was too brief, and that items were too broad and might not allow sufficient specification to identify inadequacies in assessments over time. The Facility was encouraged to consider developing additional items that would allow more specification in examining the quality of completed assessments, as well as to complete acceptable inter-rater reliability estimates to ensure its integrity and consistency across raters. Since the Monitoring Team's last visit, efforts to improve the FSA Quality Measure Grading Tool were reported. More specifically, the Facility described efforts at developing a new FSA quality assessment tool to replace the earlier, inadequate tool. The new tool, "The FSA Quality Tool," was recently developed primarily through the efforts of the Unit Directors in collaboration with the Director of Residential Services. The new tool was computer-based and was designed to closely correspond to the skill areas of the FSA. More specifically, the tool included 13 skill areas (e.g., dressing, restroom, hygiene, etc.) that assessors were required to score relative to their review of the 13 corresponding skill areas on the FSA. The tool identified "thirteen major scoring categories" and associated point values including, "excellent" (25 points), "exceptional" (20 points), "moderately excellent" (10 points), "marginally excellent" (9 points), "good" (8 points), "moderately good" (7 points), "marginally good" (6 points), "fair" (5 points), "moderately fair" (4 points), "marginally fair" (3 points), "moderately poor" (2 points), "marginally poor" (1 point), and "poor" (0 points). Instructions for the use of this tool also were developed. Based on provided documentation, it appeared that abbreviated supplemental assessments (described as "follow-up forms") were developed and designed to be completed three, six, and nine months after the initial assessment. Documentation evidenced that on 11/20/13, the Unit Directors provided an in-service training to the Residential Coordinators and QIDPs on the use of this tool. The Facility provided data as evidence that the new FSA Grading Tool was being utilized. According to the data provided, a total of 43 FSA Grading Tools were completed. This included 16, 14, and 13 completed in September, October, and November 2013, respectively. The overall average integrity scores, across two assessors, were 55% and 66% for September, 67% and 70% for October, and 80% and 57% for November. The assessors described that the November scores reflected an attempt by one assessor to rate "integrity," while the second assessor rated "content." Overall, the scores the Facility provided reflected unacceptable estimates of quality, and demonstrated substantial inconsistency across assessors. It should be noted that inter-rater reliability estimates were not generated for any of these completed assessments.	

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		In general, the Monitoring Team had serious concerns regarding the new FSA Grading Tool. First, inter-rater reliability estimates, if conducted, would be helpful to developers when determining if the tool was adequate. The lack of an inter-rater reliability estimates limited the confidence in the tool. Second, the use of 13 scoring categories, including the lack of sufficient description or definition of the each category, was problematic. Indeed, the range of potential scores as well as lack of specificity with regard to each score is likely to inhibit accurate scoring and adequate agreement across raters. Third, the tool did not include any items that examined the supplemental content areas targeted by the new FSA summary pages. It appeared critical to the Monitoring Team that this summary be completed accurately to demonstrate that the assessment was integrating findings with recommendations for skill programming. Fourth, the instructions were vague and indicated that they should be scored lower if the FSA was not completed on time. It would appear that an addition/separate item, specifically targeting whether or not the FSA was completed on time, would provide clearer information about the timeliness of completion and not artificially lower the accuracy of other items. Overall, this new tool did not provide enough specificity in scoring, and required additional items to completely assess the revised FSA. In addition to changes within the FSA quality assessment, it appeared that the format of the FSA had been revised. That is, according to verbal reports, in September 2013, the State Office released the new FSA, and on 10/1/13, the Facility implemented it. According to reports and provided documentation, the new FSA appeared very similar to the previous format except for revisions within the instructions and the addition of the Functional Skills Assessment Summary. This summary included sections that allowed for summary of an individual's history, current status, current services, preferences, strengths, and tentative goals (in the areas of living, employment, relationships, leisure interests, and independence), as well as strengths and needs as identified within areas of the assessment. In addition, this supplement provided areas for the assessor to describe contraindications to stated goals, recommendations for community living/services, as well as recommendation for SAPs and service objectives. In an attempt to examine the adequacy of currently completed FSAs, a sample of 12 individuals was selected and their FSA, as provided, was reviewed. This was the same sample as described above. Of the 12 individuals in the current sample, documentation evidenced that all (100%) of the FSAs were completed in the previous format. That is, none of the sampled FSAs were completed in the new format, dated 10/1/13. This is not surprising given that FSAs typically are completed one or two months prior to the ISP, and the sample was based on individuals with ISPs held in August, September or October. Nonetheless, the FSAs were reviewed in light that it might estimate progress on their completion even though they were missing critical elements only found in the new	

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		format. Of the 12 individuals in the current sample, documentation revealed completion of FSAs within the past 12 months for 11 (92%) individuals. The exception was the missing FSA for Individual #139. Of the 11 available FSAs, nine (82%) appeared to have been completed and filed 10 days prior to the ISP. The exceptions were the FSAs for Individual #140 and Individual #87. Of the 11 available FSAs, only five (45%) 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/needs and/or preferences/strengths (i.e., Individual #40 and Individual #170), missing information on needed supports (i.e., Individual #111 and Individual #170), and lack of determination regarding a less restrictive setting (i.e., Individual #65 and Individual #170). Lastly, although all of the FSAs had the assessors name or signature, none had a signature date. These findings were consistent with findings noted in the Monitoring Team's previous reports, and given the similar limitations and inadequacies as described above, the Facility remained out of compliance with this provision. 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	In an effort to examine whether or not SAPs effectively addressed the individuals' needs for services and supports, randomly selected SAPs were examined in a sample of individuals who had ISP meetings held since the Monitoring Team's last visit. It should be noted that the sample reviewed here was the sample previously described with regard to Sections S.1 and S.2. More specifically, available documentation was reviewed to determine if sampled SAPs were based on specific needs identified through currently completed assessments. As previously reported with regard to Section S.1, although rationales were found within all 12 (100%) of the sampled SAPs reviewed, concerns were noted with regard to the assessments cited within these rationales. Overall, each of	Noncompliance

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		the SAPs included rationales that listed multiple sources, including specific assessments (e.g., PSI, FSA, Vocational, Dental, Medical, etc.), and/or discussion by the IDT at the ISP meetings, and evidence indicated that needs related to SAPs were identified in 12 (100%) of the sampled individuals' ISPs. However, of these 12, three SAPs reportedly were based on assessments unavailable for review. For the remaining nine, it appeared that only three (33%) were based on findings within the assessments and/or specific recommendations of the identified assessment(s). The exceptions included two SAPs that were based solely on IDT discussion; three SAPs that were based on findings within assessments that, following the Monitoring Team's review, appeared inconsistent with the identified need; and one SAP based on assessments that appeared to offer contradictory findings regarding the need targeted by the SAP. The Monitoring Team found the role of individual preference in the identification of skills (or needs) and the development of corresponding SAPs less than conspicuous. That is, only one (8%) of the sample SAPs listed the PSI as one of the source assessments within the rationale section (i.e., Individual #111). And, based on the Monitoring Team's review, it was unclear if any of the targeted needs were based on individual preference. More specifically, none of the rationales provided a conspicuous description of how the SAP addressed an identified preference or a description of how preferences were integrated within the SAP, as appropriate. It was noted, however, that potential preferences might have been utilized within two of the sampled SAPs as found within descriptions of positive reinforcement for correct responding (i.e., Individual #109 and Individual #308). Overall, however, the role of individual preferences in the identification of needs and/or the development of specific SAPs was unclear to the Monitoring Team. In an effort to examine whether or not SAPs were practical and functional in the most integrated setting, the prescribed settings of current SAPs were examined. Of the 12 individuals sampled, 12 (100%) SAPs identified an instructional setting that appeared appropriate given the targeted skill. In addition, based on the Monitoring Team's review of all the provided SAPs (n=60) for the 12 individuals sampled, 11 (92%) had at least one SAP targeting implementation in a community setting, 11 (92%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings (the exception was Individual #3), and all 12 (100%) had two or more SAPs targeting implementation in the home setting. It should be noted that almost all of the sampled SAPs targeted implementation within the community primarily through generalization strategies (this is described more fully with regard to Section S.3 of the Settlement Agreement). In addition, the 12 sampled SAPs were reviewed to examine whether or not they were practical and functional. Overall, it appeared that all of the sampled SAPs targeted (or intended to target) skills that were meaningful and potentially useful for the individual.	

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		However, although well intended, it was noted that inadequacies within the SAPs questioned the degree to which the strategies would ultimately be successful in supporting the acquisition of these skills in appropriate settings. For example, although choice making and communication are important skills, it appeared unlikely that staff could identify and/or prompt a correct response for Individual #109 and Individual #139. In the end, although the majority of SAPs appeared to target skills that were useful and meaningful, as previously noted it was unlikely that the majority of SAPs were currently promoting growth, development, and independence across most individuals served at LBSSLC. As noted in Monitoring Team's previous reports, SAP observation probes were completed to estimate staff knowledge and skills in implementing SAPs. That is, the Skill Acquisition Program Observation examined demonstrative indicators (i.e., based on implementation of the SAP) and staff knowledge (i.e., based on verbal report of information on the SAP), as well as two questions that examined the adequacy of data collection (i.e., based on record review). As previously noted, this rubric had been frequently revised given the concerns with its adequacy. Indeed, as detailed in the previous report, the Monitoring Team recommended that the rubric be more closely aligned with critical elements found within the SAP. This included, for example, the addition of questions that would facilitate: 1) determining if staff could 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. In addition to these suggestions, the Facility was also encouraged to increase the number of integrity probes conducted as well as conduct inter-rater reliability checks. Currently, it appeared that the Facility had revised the SAP observation probe, but it was unclear whether or not this revision was inline with the previous recommendations listed above. The revised integrity check, entitled the "Skill Acquisition Treatment Integrity Monitoring Form," included four additional questions, with three targeting data collection. It was unclear to the Monitoring Team which item was the remaining (additional) question. Review of the questions appeared to evidence that the questions were revised in an effort to address some of the concerns. However, not all of the concerns were addressed. For example, items were not included targeting whether or not staff could identify and/or use the appropriate instructional method (forward, backward, total task), or whether they could identify when to change steps or change prompt level across trials. However, additional items examining the adequacy of data collection were found. One additional data collection item might include the examination	

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		of whether or not the staff recorded correct (+) or incorrect (-) responses adequately across trials. Overall, the apparent revisions seemed likely to improve the ability of IPDs and Active Treatment staff in estimating direct support professionals' ability to implement SAPs with integrity. It is expected that this form will likely be revised again in the future as improvements in implementation (e.g., generalization trials) and data collection occur. Summary documentation reviewed in the Monitoring Team's previous report revealed only a small number of treatment integrity observation probes conducted in January and February 2013. Data from February and March 2013 was provided that evidenced the completion of SAP program observation probes in some homes across four raters, but monthly probes were not conducted within several of the programs. In addition, given the inexperience of the newly hired IPDs, onsite observation of integrity probes was not conducted. At that time, the Monitoring Team determined that the Facility had yet to demonstrate evidence that SAPs were consistently implemented with a high degree of integrity. Currently, provided documentation appeared to reflect summary data from previous and current SAP treatment integrity monitoring. More specifically, skill acquisition treatment integrity monitoring summary results, dated 11/21/13, from "the last six months" was provided. This data included a total percent for each item and, because 14 questions were evident, it appeared that the summary data was the product of completed integrity forms utilizing the older format. It should be noted that the Monitoring Team assumed that these percentages were averages calculated across an unknown number of completed monitoring forms. That is, no descriptive information of any kind was provided. Nonetheless, summary data included percentages that ranged from 62% to 100%, with a calculated competence and documentation score of 91% and 65%, respectively. Overall, the data allowed some insight with regard to where direct support professionals were more or less knowledgeable and/or successful in implementing the SAPs, including their accurate data collection. Given the provided summary data, it appeared that assessed staff struggled with providing the correct cue (discriminative stimulus), as well as with accurately recording data as prescribed. Summary data based on the most recently revised SAP treatment integrity monitoring forms also was provided (i.e., only for November 2013). This summary data was based on 76 completed integrity monitoring forms and listed percentages that ranged from 43% to 98%, with a calculated competence and documentation score of 86% and 62%, respectively. Similar to the summary data generated by the previous integrity form (described above), the percentages allowed insight with regard to where direct support professionals were more or less knowledgeable and/or successful in implementing the SAPs, as well as in accurately collecting data as prescribed. Given the provided summary	

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		data, it appeared that, in general, assessed staff struggled with demonstrating many of the necessary teaching responses (i.e., four of nine items below 79%), had difficulty describing generalization strategies (i.e., 79%), and were likely to inaccurately record data as prescribed. As presented in the Monitoring Team's previous report, it was recommended that the Facility track data on the number of probes completed within each program each month, as well as monitor the estimated level of SAP treatment integrity. Currently, only average percentage scores were reported. However, the Facility might find it helpful to monitor the range of scores by item, as well as collapsed across the knowledge and demonstration items, as well as compliance and documentation across programs and over time. This additional data might allow examination of how many staff met the acceptable competency criteria and how many staff required re-training. In addition, the availability of more data might facilitate better progress through more informed decision-making. For example, the Facility might find that knowledge scores tend to artificially inflate competence scores (i.e., because staff are allowed to read the SAP to find the correct answer). Consequently, eliminating these knowledge-based items (or items answered through reading) when determining the overall competence score might place greater emphasis on accurate demonstration of required responses, and, as a result, generate more accurate estimates of treatment fidelity. It was noted that the Facility had developed a weekly/monthly schedule to assist with organizing and implementing SAP integrity monitoring probes the IPDs and Active Treatment staff conducted. In addition to this system, a system was still necessary to effectively track the completion of these probes and related data. The Monitoring Team did not directly observe staff conducting SAP integrity monitoring probes during the Monitoring Team's previous onsite visit. This decision was in response to the Facility's assertion that newly hired IPDs were not yet experienced in conducting integrity probes. Consequently, since the Monitoring Team's last visit, questions remained regarding the adequacy of SAP integrity checks. Currently, in an effort to examine the adequacy of integrity checks, a member of the Monitoring Team observed the completion of two integrity checks conducted at the Small Workshop (with Individual #137) and at Maple (with Individual #3). Overall, current observations reflected the need for ongoing support and training for IPDs and Active Treatment staff members who conduct these sessions. More specifically, staff continued to appear confused regarding some elements within the SAPs, as well as how to accurately score responses. In addition, direct support professionals who volunteered to be observed appeared to have difficulty answering simple questions about the SAPs even with the plan at hand. Indeed, the lack of fluency in answering questions common to all SAPs, implementing the targeted SAP as prescribed, and continued uncertainty by raters raised	

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		concerns with regard to integrity monitoring. In addition, the Monitoring Team intended to watch the raters complete inter-rater reliability estimates during both observations as well. Unfortunately, one of the raters did not complete the integrity check as planned (during the first observation), and the remaining pair of raters (during the second observation) only evidenced an approximate 72% agreement estimate. Lastly, raters should consider asking staff to answer questions without reading the answers off of the actual SAP. Items that are simply read by staff do not necessarily reflect their knowledge or ability to understand the program or their ability to implement the SAP. As a result, accurate responding to primarily knowledge-based questions, especially when the staff member is allowed to read the answer, might artificially inflate integrity scores. Indeed, knowledge-based answers make up approximately one-third of the items producing the competency score. The Monitoring Team recognizes that completing integrity checks with a high degree of fidelity and reliability is challenging. The Facility is commended for continuing to conduct these checks, especially given the recent decision to involve Active Treatment staff in these checks as well. A primary concern of the Monitoring Team is the degree to which independent observers agree when scoring items during SAP integrity checks. That is, given the current findings from direct observations of integrity checks, the Monitoring Team questioned the competency and consistency of raters when completing these checks, as well as their independence in scoring the checklists. Consequently, the Facility is strongly encouraged to emphasize the collection of inter-observer agreement estimates between raters during integrity checks. Indeed, a sample of integrity checks that include inter-observer agreement estimates should be completed each month for each rater. Perhaps the majority of SAP integrity checks could be completed in pairs (by independent raters) to ensure concurrent estimates of quality as well as inter-rater reliability, and the Facility should pursue opportunities for on-going training until acceptable rates of both are established. 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 data from September, October, and November, as requested and provided, was reviewed. It should be noted that review of data from this sample (n=12) was challenging, because the selected individuals had ISP meetings in August (n=2), September (n=4), and October (n=6) and, consequently, SAPs for half the individuals sampled were not implemented until mid to late October or after. As a result, current review of data might only include data from less than two complete months. It should be noted that December data sheets were not requested due to the close proximity with the current onsite visit dates. Nonetheless, review of the provided raw data indicated: ▪ For individuals with ISPs in August (n=2), completed data sheets for all three months (September, October, and November) were provided for one (50%) of	

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		the selected SAPs. That is, the data sheets were only provided for Individual #111, and not Individual #40; ▪ For individuals with ISPs in September (n=4), completed data sheets for two months (October and November) were provided for three (75%) of the selected SAPs. Indeed, only the November data sheet was provided for Individual #170; ▪ For individuals with ISPs in October (n=6), completed data sheets for one month (November) were provided for six (100%) of the selected SAPs. For some individuals with ISPs in early October, corresponding data sheets were available from October for two individuals (Individual #3 and Individual #240). Overall, based on provided documentation, it appeared that completion of data sheets for sampled SAPs was inconsistent but, as noted above, appeared to improve over time. More concerning, however, was the quality of data collection reflected on completed data sheets. More specifically, closer examination of available data sheets revealed several concerns with regard to the data collected and how it was recorded (or not). The current reviewed found that, even when data was collected, it was not collected as prescribed for most individuals. More specifically, of the 12 individuals sampled, only the data sheets for one (8%) individual appeared completed adequately (i.e., Individual #65). It should be noted, however, that this data sheet evidenced seven trials during which the individual refused to complete the SAP. Consequently, although accurately completed, the majority of data typically recorded during acquisition trials was not recorded. Overall, the majority of sampled data sheets were completed inadequate. This included, for example, cases where forward chaining was prescribed, yet data on all task analysis steps was recorded (e.g., Individual #140, Individual #111, Individual #3, Individual #87, and Individual #240) or vice versa (e.g., Individual #97), as well as cases where data on "attempted prompts" and/or "correct/incorrect" was simply recorded inconsistently, inaccurately, or not recorded (e.g., Individual #140, Individual #109, Individual #139, Individual #170, individual #308, individual #87, individual #97, and Individual #240). In an effort to examine the nature of data collection with regard to dental and medical SAPs, a sample of individuals was selected from those the Facility identified as having dental and/or medical SAPs. Of these, a sample of eight individuals was selected and their medical and/or dental desensitization SAPs, as well as corresponding raw data sheets for September, October, and November were requested. Upon review, this sample included a total of eight SAPs, including four targeting dental desensitization (i.e., Individual #103, Individual #79, Individual #8, and Individual #299), as well as four targeting medical desensitization (i.e., Individual #6, Individual #175, Individual #47, and Individual #119). It should be noted that December data sheets were not requested due to the close proximity with the current onsite visit dates. Nonetheless, review of the SAPs as well as the corresponding raw data sheets for September, October, and November 2013, as provided, indicated:	

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		▪ Seven (88%) of the SAPs appeared to be completed in a more recently revised format. The exception was Individual #6; ▪ Of the eight individuals, September data sheets were provided for five (63%) of the SAPs; ▪ Of the eight individuals, October data sheets were provided for six (75%) of the SAPs; ▪ Of the eight individuals, November data sheets were provided for seven (88%) of the SAPs; ▪ Of the eight individuals, data appeared to be recorded as scheduled on the available data sheets for four (50%) of the SAPs. This included Individual #175, Individual #8, Individual #299, and Individual #119; ▪ Of the eight individuals, data appeared to be recorded accurately (i.e., consistent with the specified teaching methodology) and completely on the available data sheets for one (13%) of the SAPs (i.e., Individual #175); and, ▪ Review of available data sheets revealed the recording of significant numbers of refusals each month (at times, involving over half of the data collected) for four (50%) of the individuals sampled. Overall, significant concerns with the adequacy of data collected on dental and medical desensitization SAPs were noted (as described above). Closer examination of available data sheets revealed concerns with missing data, data recorded inaccurately, and poor monitoring of performance over time. That is, the programs of several individuals should have been modified based on their ongoing performance, but were not (e.g., Individual #47, Individual #299, and Individual#119). This inadequate monitoring appeared related to actual loss of progress for two individuals (i.e., Individual #47 and Individual #119). Overall, the majority of sampled data sheets were completed inadequately, and, as a result, would not support SAPs in promoting growth, development, and independence across most individuals served at LBSSLC. In general, based on the review of the sampled raw data sheets, significant concerns remained with regard to the adequacy of data collection and, consequently, the effectiveness of 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. This would include more specific directions on the SAP and/or on data sheets regarding the completion of all data, including "attempted prompts," "Correct/Incorrect," and "Trials." In addition, this would include ensuring consistency in the format utilized for data sheets. More specifically, most appeared to have been formatted to include data on treatment integrity, but formatting to support data related to generalization trials was not consistently found.	

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		Brief onsite reviews during the current Monitoring Team visit evidenced mixed findings with regard to the adequacy of behavior and SAP data collection. In an attempt to estimate the adequacy of behavior data, during visits to several residences, a member of the Monitoring Team asked questions of randomly chosen direct support professionals with regard to data collection methods, including the use of index cards. It should be noted that reviewing recorded behavioral data was somewhat of a challenge, because individually completed index cards were not easily accessible (i.e., not stored in individual records). Consequently, the Monitoring Team used an indirect method to estimate staff's ability to effectively collect data. More specifically, the Monitoring Team examined whether or not staff members were knowledgeable about data collection, including the specific use of the index cards, and whether or not they could immediately produce their index card. This method was viewed as a way to indirectly estimate direct support professionals' adherence to prescribed data collection processes. A member of the Monitoring team informally interviewed a small sample of eight randomly selected direct support professionals across six residential programs (i.e., Aspen, Birch, Elm, Rose, Zinnia, and Iris). Of the eight staff questioned, seven (88%) appeared knowledgeable about data collection methods, including the intent and use of the index cards. However, of the eight, only four (50%) were able to immediately produce their index card. Consequently, it appeared that only half of the staff sampled closely adhered to expected data collection methodology. In addition to estimating adherence to prescribed behavior data collection methods, the Monitoring Team also examined the adequacy of collected SAP data. More specifically, in an attempt to estimate the adequacy of SAP data, a member of the Monitoring Team reviewed several randomly chosen records during onsite visits to residential programs. As a permanent product review, this method was viewed as an indirect estimate of staff's ability to effectively collect data. A member of the Monitoring Team randomly selected a small sample of 12 individuals from across 11 residential programs (i.e., Willow, Oak, Birch, Elm, Fir, Maple, Canna, Rose, Violet, Zinnia, and Iris) and reviewed available SAPs and SAP data sheets as found within their records. Data appeared to be collected for 90% (or more) of prescribed opportunities for eight (67%) individuals (i.e., Individual #276, Individual #22, Individual #109, Individual #67, Individual #80, Individual #87, Individual #174, and Individual #70) and above 80% for two (17%) other individuals (i.e., Individual #46 and Individual #172). Lower percentages of completed data were found for Individual #155 (75%) and Individual #77 (58%). It should be noted that these percentages reflected whether or not data was actually recorded on the data sheets consistent with the days prescribed within the SAP methodology. That is, the Monitoring Team was looking to determine if data was taken when scheduled. It was found, in many cases, that more data was actually collected than was prescribed. More importantly, however, were serious concerns noted with regard to the quality of the data collected. That is, although recorded data appeared to adhere to the schedule of when data was to	

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		be collected (at a minimum), the data itself appeared to be erroneous. That is, nine (75%) of the individuals sampled had data sheets that appeared to be completed inaccurately or the Monitoring Team could not determine which step(s) should have been completed. This included Individual #155, Individual #22, Individual #109, Individual #67, Individual #46, Individual #87, Individual #172, Individual #77, and Individual #70. Most of these included data (or omitted data) that was inconsistent with the teaching methodology currently in place. More specifically, data was collected across a single step when total task was identified or data was collected across all steps when forward or backward chaining was identified. These errors appeared to affect the data collection of two or more SAPs for six (50%) of the individuals sampled. Overall, although direct support professionals appeared to be collecting data when prescribed, recorded data evidenced considerable difficulty in accurately recording this data. As reported in the Monitoring Team's previous report, the Monthly Review was a new format that was developed and introduced to facilitate 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 of any changes with regard to the PSI or other sources of data (e.g., observation notes, integrated progress note). Each month, the QIDP was expected to specifically examine progress on each formal training objective and provide a summary. At that time, the Monitoring Team found the collection and monitoring of SAP data was inadequate. In an effort to examine the nature of progress monitoring as reflected through Monthly Reviews, samples from September, October, and November were requested and reviewed. That is, Monthly Reviews completed for three months, as provided, were examined for each of the 12 individuals within the sample (as described above). The Monitoring Team examined the correspondence between the Monthly Review and the actual monthly data sheets, the comprehensiveness and quality of the data review, and the timeliness of their completion. For the 12 individuals sampled, the following was found: ▪ Monthly notes for the months of September, October, and November were available for 12 (100%) of those sampled. However, it appeared that the November note for Individual #170 was incomplete (missing pages); ▪ Of the 12 individuals, nine (75%) monthly notes for November appeared to correspond to the SAPs provided for review. The exceptions included Individual #65, Individual #170, and Individual #40; ▪ Of the 12 individuals, descriptions of current status for identified SAPs were found within the text of 10 (83%) monthly notes for November. The exceptions included Individual #170 and Individual #308. However, it should be noted that in several of the monthly notes, descriptions were often brief, cryptic, and did	

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		not include reference to data; ▪ One or more graphic displays of data appeared in 11 (92%) individuals' monthly notes. The exception was Individual #170. However, graphs appeared to be missing in the monthly notes of some individuals. That is, graphic displays corresponding to all identified SAPs were not found in the monthly notes of Individual #65, Individual #140, and Individual #40; and, ▪ Although graphs were included in the monthly notes of almost every individual, none (0%) of the graphs could be easily interpreted. That is, necessary elements (e.g., descriptive titles, axis labels) were missing or inadequate, and the Y-axis metric (i.e., steps of the task analysis) did not facilitate interpretation. Overall, consistent with findings of the Monitoring Team's previous reviews, the adequate and timely monitoring of skill acquisition data continued to be inadequate.	
	(b) Include to the degree practicable training opportunities in community settings.	As detailed in the Monitoring Team's previous report, of the 57 SAPs sampled, 5% targeted the community as the primary setting for instruction. It was found that the community (or a specific community-based setting) was identified as a setting for implementation within generalization strategies in one or more SAPs for 79% of the individuals sampled. At that time, it was noted that strategies related to community-based implementation were vague and did not typically include specific instructions for generalization and usually encouraged implementation only after the skill was acquired. Currently, of the 60 SAPs sampled (i.e., as previously discussed with regard to Section S.1 of the Settlement Agreement), 3% targeted the community as the primary setting for instruction and 42% targeted the community within generalization strategies. This finding revealed that 14 (88%) of the individuals sampled had one or more SAPs targeting community implementation. Similar to previous findings, it was noted that strategies related to community-based implementation continued to be vague and did not include specific instructions (e.g., when, where, etc.) for generalization and only encouraged implementation after the skill was mastered. Overall, since the Monitoring Team's last visit, opportunities for instruction in community settings did not appear to improve. That is, the primary setting for instruction identified in almost every SAP was the home or other setting on campus. And, although community settings were identified more frequently in SAPs as part of generalization strategies, the inadequacy or omission of specific plans to support generalization appeared to limit training opportunities in the community. In addition, most SAPs included generalization strategies that prescribed implementation only once the skill was mastered. Lastly, although noted in several of the Monitoring Team's previous reports, there continued to be no systematic method for monitoring SAPs targeted for completion in the community as well as individual performance on these	Noncompliance

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		SAPS in the community over time. It should be noted that the Vocational Department provided a listing of names of individuals with SAPs targeting completion in the community, but specific information on the nature of the SAP, data collection, and/or progress was not noted. 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 potential methods to promote generalization. And, a monitoring system to effectively track progress on these community-based training opportunities should be developed and implemented. As reported in the Monitoring Team's previous reports, summary data of community outings reflected insufficient opportunities for community outings for many individuals the Facility served. For example, provided summary data from 9/11 to 2/12, 3/12 to 9/12, and 9/12 to 5/13 indicated an overall range of 54 to 165, 70 to 114, and 50 to 96 total outings per month, respectively, across all residential programs. In the past, this data consistently showed several programs with typically no (or minimal) community outings each month. These included Quail, Sparrow, Iris, Zinnia, and Willow. Currently, the Facility reported summary monthly data of the number of individuals that attended a community outing, the percentage of individuals that attended a community outing, and the total number of trips since the Monitoring Team's last visit. Summary data from May to December 2013 indicated a range of 80 to 181 total individuals that attended a community outing per month across all residential programs. Provided summary data from May to October 2013 also indicated a range of 65 to 137 total number of community outings per month across all residential programs. Lastly, summary data from May to October 2013 also indicated a range of 53% to 85% total percent of residents who attended a community outing per month across all residential programs. Although recent data reflected a slight improvement in the number of community outings compared to previous data, there were still several programs that had no (or only a few) individuals experience community outings in two or more months since the Monitoring Team's last visit. These included Quail and Sparrow, and, to a lesser degree, Iris, Zinnia, and Willow. Consequently, the programs consistently noted with the lowest number of community outings continued to experience difficulty in enhancing the community integration for their residents over time. Overall, when comparing current opportunities for community outings with previous rates, there seemed to be a slight increase (a higher range of scores) in the last year. However, data reported since	

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		September 2011 indicated a decreasing trend (and restricting range) over time. Similar trends were reflected in the current data as well. That is, provided data from May to December 2013 reflected decreasing trends over time in the number and percentage of individuals participating in community outings each month. In addition, data from this time period reflected a dramatic decreasing trend in the number of community outings offered each month over time. Overall, since the Monitoring Team's last visit, slight improvement was noted in providing opportunities for community outings. 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. The Facility remained in noncompliance with the provision.	

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 DADS Policy Number 018, entitled "Most Integrated Setting Practices," dated 10/18/13; o LBSSLC – Continuity of Services: Most Integrated Setting procedure, revised 12/5/13; o List of individuals referred for placement, undated 11/20/13; o In response to request for list of individuals who have requested community placement, but have not been referred, the following statement: "For the timeframe between May 15, 2013 to November 15, 2013, there have been no individuals who have requested community placement that have not been referred;" o List of individuals not referred due to Legally Authorized Representative (LAR) preference, data pulled from 5/15/12 to 11/15/13; o List of individuals transferred to the community since the last onsite review, from 7/6/13 to 11/15/13; o Note that since the last onsite review, no individuals were discharged pursuant to an alternate discharge, undated; o Note that since the last onsite review, no individuals were 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, dated 5/15/13, 6/17/13, 7/17/13, 8/13/13, 9/27/13, and 10/16/13; 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, data collected from 11/15/12 to 11/15/13; o For the last six months, 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 5/15/13 to 11/15/13; o Facility and Local Authority 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 5/29/13; o "LuSSLC Obstacles Report – All Obstacles Reporting Dates: 9/1/12 to 8/31/13," dated

	11/7/13; 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 #124); 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 have not been any deaths of individuals who have moved from LBSSLC since 7/1/09;" o Community Placement Report, from 5/15/13 through 11/15/13; o Community Living Discharge Plan, related assessments, sign-in sheet, and most recent ISP for: Individual #19, Individual #79, and Individual #259; 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 #97, Individual #20, Individual #7, Individual #109, Individual #240, Individual #3, Individual #214, Individual #315, Individual #21, and Individual #139; o Pre-Move and/or Post-Move Monitoring Checklists for: Individual #64, Individual #61, Individual #291, Individual #124, Individual #81, Individual #19, Individual #259, and Individual #79; o State Office reviews conducted for CLDPs for Individual #19, and Individual #79; 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 Meeting minutes and documentation showing Admissions Placement Department meetings with the Local Authority (LA); o ISP, related assessments, and ISPAs or other documentation related to community transition and/or rescinding the referral for Individual #264, and Individual #27;

	○ Assessment logs for Individual #19, Individual #79, Individual #259, and Individual #291; ○ ISPAs related to transition for Individual #19, Individual #79, Individual #259, Individual #240, Individual #291, Individual #61, and Individual #124; ○ Post-move Monitor's contact logs for Individual #64, and Individual #61; ○ Documentation to show that individuals whose teams included an action plan for a community tour went on a tour, including the date; ○ Transition Specialist report regarding medical staff's participation in exposure tours and provider fairs; ○ Provision Action Information, updated 12/17/13; ○ LBSSLC Self-Assessment, updated 12/20/13; ○ Action Plans for Section T, dated 12/17/13; and ○ Presentation Book for Section T. ▪ **Interviews with**: ○ Carla Prell, Admissions/Placement Coordinator; Annette Webster, Post-Move Monitor; Georgia Howard, Transition Specialist; and Jennifer Smith, Transition Specialist; and ○ Sandra Kennedy, QDDP Coordinator; Christina De Los Santos, QDDP Educator; Marc Lopez, Systems Analyst; and Autumn Warfel, ISP Technician. ▪ **Observations of**: ○ ISP meeting for Individual #264.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 12/20/13. 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 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: ○ 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. ○ The Admissions Placement Coordinator indicated that in recent months, changes were being made to the monitoring tools used, as well as the processes. For example, the Admissions Placement Coordinator indicated she expected to attend a meeting at which the draft tools would be finalized. In addition, some of the responsibility for monitoring requirements of Section T was being shifted to the QIDP Department, and PCM assigned to

	work with Section F. o The monitoring tools in use during this review period 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. In addition, guidelines/standards were insufficient. Based on review of the draft tools State Office recently issued, these tools identified the methodologies (i.e., where to look for the information), but no standards or guidelines were included to facilitate consistency between reviewers. Although a number of the indicators appeared to address some quality expectations, as opposed to mere presence of items, without standards, it will be difficult to ensure consistency across reviewers. o The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size) to provide a sense of whether or not they were representative samples. o With regard to the staff/positions responsible for completing the audit tools, as discussed above, this was in the process of changing, and would soon include staff from the Admissions Placement Department, QIDP Department, and QA Department. It will be important moving forward to establish inter-rater reliability across the various staff responsible for monitoring. o It also will be important for the staff responsible for monitoring to been deemed competent in the use of the tools. ▪ The Facility 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, and when quality was assessed, it was unclear what standards the Facility used. 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 substantial compliance with the following sub-sections of Section T: T.1.c.2, which requires specifying staff responsible and timeframes for completion of

	action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.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 consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in substantial compliance with the following sub-sections: T.1.c.2, T.1.c.3, T.1.h, and T.4. The Monitoring Team did not find the Facility in substantial compliance with Section T.2.a, but did find the Facility in substantial compliance with Section T.2.b, which the Facility cannot assess. ▪ The Facility data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment minimal analysis of the information, but did reference 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, but some did not. 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. When team members modified the opinions they had included in their assessments, generally no explanation was provided. Systemic issues appeared to prevent referrals, and clear action was not being taken to resolve them. For example, at the ISP meeting for an individual who was not referred due to LAR Choice, the team discussed what was described as a DADS Guardianship Specialist policy that required individuals to have "no incidents for six months before [the DADS Guardianship Specialist] will consider community placement." Although the team appropriately questioned the policy, there was no indication that the team raised this significantly concerning "DADS Guardianship Specialist policy" to a higher level for review. Similarly, when this individual later was referred, and then the referral was rescinded, Facility staff, as well as the DADS Guardian discussed behavioral criteria he would need to meet for the referral to be reopened. Individuals with behavioral challenges should be able to be supported in community settings, including individuals who exhibit behaviors that might necessitate physical intervention. It was concerning that team members were setting criteria that involved individuals maintaining certain numbers of behavioral incidents and/or restraints as prerequisites for referrals. Along similar lines, systemic issues that negatively impacted referrals and had not been addressed were gaps or perceived gaps in supports in the community for individuals with complex behavioral and/or medical and physical and nutritional management needs. In the last report, the Monitoring Team raised issues regarding teams potentially delaying referrals to allow family members opposed to transition to obtain guardianship. During this review, review of individual records and other documentation showed evidence of this practice. These practices were inconsistent with the Settlement Agreement requirement that: "the State shall take action to encourage and assist individuals to move to the most integrated settings…" In none of these cases was evidence found that teams had developed detailed and individualized action plans to work with families to identify community living options that could address their specific needs.

	Although teams were identifying obstacles to referral, they sometimes did not include all of the concerns the team had identified in their discussion. Action plans were not being developed for all obstacles. In addition, action plans that were being developed were insufficient 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. Although most individuals had plans in their ISPs related to educational opportunities on community options, 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 needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Expansion of efforts to share success stories was needed, particularly for individuals and guardians who were reluctant. On a positive note, some assessments developed in preparation for CLDP meetings had begun to include more detail regarding the protections, treatments, and supports that individuals needed (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.). Although much more work was needed, it was positive that some disciplines were beginning to include more detail. Of significant concern was the fact that these more detailed recommendations were not being translated into necessary pre- and post-move required supports. Many pre- and post-move required supports continued to be missing from CLDPs, including some extremely important supports necessary to protect the wellbeing of the individuals transitioning to the community. At the time of the Monitoring Team's last review, three individuals that had transitioned to the community since the Settlement Agreement was signed recently had returned to the Facility, and two of these individuals were in jail before returning. Since the last review, another individual had returned to the Facility. As noted in previous reports, the Facility was not conducting root cause analysis reviews of even these most critical incidents to determine specifically whether or not changes should be made to the CLDP development or implementation process. 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 confirmation that pre-move supports were in place prior to the individual's transition to the community. Although based on observation, the Post-Move Monitor appeared to conduct thorough post-move monitoring, review of documentation did not consistently show that findings were well supported. It is important that clear

	evidence be provided to support the findings and to increase the likelihood that community providers will respond to them.

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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.	Based on the Community Placement Report, for the time period between 5/15/13 and 11/15/13, as well as other lists the Facility provided, the transition-related numbers were as follows: ▪ Seven individuals completed transitions (3% of population); ▪ Referrals for community placement: o Eight individuals were on the active referral list (4% of population); o Eight individuals were referred since last visit; o Two individuals had been on list more than 180 days; and o One individual had been on the list for more than one year; ▪ Reportedly, no individuals had requested placement, but were not referred; ▪ Twenty-two (22) individuals would be referred except for LAR preference (i.e., the IDT would refer); ▪ Two individuals' referrals were rescinded; ▪ Potentially negative outcomes (the Facility's compliance related to review of these is addressed with regard to Section T.1.f): o One individual had returned from community placement; o No deaths had occurred following community placement; and o Two other potentially negative outcomes (e.g., psychiatric hospitalization, ER, police contact, change in community provider or residence); and ▪ No individuals were discharged pursuant to Section T.4. As is discussed with regard to Section T.1.b.3, the determinations of professionals regarding individuals' transition to the most integrated setting appropriate to their needs continued to be an area required focused efforts. 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. <u>Placement and Referral Not Opposed</u> a. In reviewing the CLDPs and ISPs for three individuals who had been placed (i.e., Individual #19, Individual #79, and Individual #259), three (100%) individuals and/or LARs did not oppose transition to the community.	Noncompliance

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		Responding to Individual Requests and Rescinded Referrals b. According to documentation the Facility provided, since the last review, there were two rescinded referrals (i.e., Individual #27, and Individual #264). ▪ Of these, the reasons for the rescinding appeared to be reasonable for two (100%) (i.e., LAR Choice for Individual #27 and Individual #264). ▪ Further, an adequate review to determine if changes were needed in the referral and transition-planning processes at the Facility was conducted for none (0%) of the rescinded referrals. The Facility submitted no documentation to show that a critical review had been completed of the rescinding of these referrals. The Monitoring Team's review of the documentation showed significant concerns for each individual that should have been reviewed, and addressed. For example: o As discussed in further detail below, the discussions related to Individual #27's referral and the rescinding of the referral showed a lack of understanding of criteria that should or should not be used when making referrals. o In addition, Individual #264's team documented decisions in ISPAs to put the referral on hold to allow a family member to obtain guardianship with the intent to halt the referral (i.e., in ISPAs dated 6/25/13, and 9/27/13, "It was originally determined that his sister would be given 45 days to obtain guardianship. At this time that [sic] the intent is to halt the referral. Therefore the IDT is in a position to place the referral process on hold"). As discussed in the Monitoring Team's last report, this was not consistent with 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…" Alternatives that did not appear to have been pursued included 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. ▪ Because no reviews were conducted, the following indicator could not be completed: Of these reviews, actions were recommended in ___ cases. Of these cases, actions were implemented for ___ (%). c. Reportedly, no individuals requested placement, but were not referred. As a result, the following indicator was not applicable, but will be reviewed during upcoming reviews: Of the ___ individuals who requested placement, but were not referred, individuals had an LAR who made this decision. Of the remaining ___ individuals, an appropriate review, appeal, and or lack of consensus review was conducted for ___ (%).	

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		Systemic Issues d. There were systemic issues delaying referrals (at the State and/or Facility level). Even though there were some, there were not actions being taken to resolve them. For example: ▪ At the ISP meeting for Individual #27, who was not referred due to LAR Choice, the team discussed what was described as a DADS Guardianship Specialist policy that required individuals to have "no incidents for six months before [the DADS Guardianship Specialist] will consider community placement." After some discussion from the other team members, who appropriately raised concerns that this was unrealistic, the DADS Guardianship Specialist indicated that: "if [Individual #27] had no more than one restraint per month, she would consider referral." His referral was rescinded based on LAR choice, despite the fact that the rest of the team at the meeting recommended referral. There was no indication that the team raised this significantly concerning "DADS Guardianship Specialist policy" to a higher level for review. Later in the year, Individual #27 was referred. The documentation the Facility provided did not indicate why the LAR had changed her mind, nor did it provide any information about the individual's behavior at the time of the referral. A few months later, the team met, and the referral was rescinded. During this meeting, the Facility psychiatrist stated: "in his professional opinion [Individual #27] needed to have six months on stable behaviors and minimal restraints for him to consider a referral." Based on the documentation the Facility provided, the team was basing the referral on the individual's behavior, as opposed to making a determination of whether or not a community provider could be identified to support the individual with his behavior challenges. Individuals with behavioral challenges should be able to be supported in community settings, including individuals who exhibit behaviors that might necessitate physical intervention. It was concerning that team members were setting criteria that involved individuals maintaining certain numbers of behavioral incidents and/or restraints as prerequisites for referrals. Of further concern, no action plan was included in the ISP or ISPA that rescinded the referral for Individual #27 related to identifying providers that could support an individual with complex behavior needs. ▪ Based on review of a sample of 10 ISPs, the lack of or the perception of a lack of supports in the community for individuals with complex medical and/or physical and nutritional management needs (e.g., Individual #139, Individual #21), and/or complex behavioral needs (e.g., Individual #109 and Individual #7) were systemic issue delaying referrals. Based on discussion with Facility staff as well as the Monitor's recent discussions with the parties, systemic actions to resolve these issues were not being implemented.	

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		▪ In the last report, the Monitoring Team raised issues regarding teams potentially delaying referrals to allow family members opposed to transition to obtain guardianship. During this review, review of individual records and other documentation showed evidence of this practice. For example, notes related to guardianship for Individual #79 stated: "…[Individual #79]… has just been referred for community placement and her family is opposed to the referral. They will need guardianship info… They will also need a certified letter stating they have 45 days to pursue guardianship before we continue with the referral." Similarly, guardianship notes indicated: "Lubbock State Supported Living Center will now precede with [Individual #264's] community referral since there has been no further progress regarding his guardianship." His referral was eventually rescinded after a family member that reportedly had had little contact or involvement with him for years obtained guardianship. The ISP for Individual #21 indicated that the Local Authority staff had included information about obtaining guardianship in the paperwork sent to inform the family about community living options. His ISP indicated the family preferred that he remain at LBSSLC, and "The team discussed the concern of [Individual #21's] family not having a guardian [sic]. By having guardianship over [Individual #21], [his] family will be able to have more control over [his] rights in regards to medical and living options." These practices were inconsistent with the Settlement Agreement requirement that: "the State shall take action to encourage and assist individuals to move to the most integrated settings…" In none of these cases was evidence found that teams had developed detailed and individualized action plans to work with families to identify community living options that could address their specific needs. e. Based on review of documentation and interviews with staff, there were no existing and/or potential systemic issues delaying transitions (at the State and/or Facility level). If there were any, the following indicator would have been assessed: If there were any, there **were/were not** actions being taken to resolve them. f. Funding availability was not cited as a barrier to individuals moving to the community. g. Senior management at the Facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The Admissions Placement Coordinator presented information regularly at the QA/QI Council meetings, and it was clear from discussion with the Assistant Director of Programs that she had been kept informed of the status of referrals and transitions. <u>Pace of Transitions</u> h. At the time of the review, transitions were occurring at a reasonable pace. However, it	

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		should be noted that the Facility had very few referrals, and problems were noted with regard to the justifications teams had included in ISPs for not referring individuals. As referrals increase, the rate at which transitions occur might change. ▪ Of the four individuals placed since the time of the last onsite review, four (100%) were placed within 180 days of their referral. ▪ At the time of the review, eight individuals had been referred for community transition. Two of these eight individuals had exceeded the 180-day timeframe (i.e., Individual #240 and Individual #259). o Of these, one individual had exceeded one year (i.e., Individual #240). i. Reasonable activity and actions had occurred related to the transition and placement for one of the two (50%) individuals (i.e., Individual #240. For Individual #240, the issues preventing transition were related to guardianship, and were largely outside of the purview of the Facility. The ISPAs for Individual #240 provided updates on the status of the guardianship proceedings. However, for Individual #259, the ISPAs for the time period beyond the 180 days did not provide sufficient detail to determine what actions the Facility had taken. j. The following indicator could not be completed, because insufficient information was available for Individual #259: There were no gaps of time (e.g., multiple months) during which little or no activity occurred for ___of the one (%) individuals. For Individual #240, this was not applicable, because the Facility did not have control over the legal proceedings. k. Adequate justification was provided for the lengthier transition process for two of the two (100%) individuals. 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:	a. The state policy for most integrated setting practices was recently issued. The Monitoring Team will comment at the next review as to whether the State policy adequately addressed all of the items in Section T of the Settlement Agreement. b. There were not Facility policies that supported the state policy for most integrated setting practices. Although on 12/5/13, the Facility issued a procedure entitled: "LbSSLC – Continuity of Services: Most Integrated Setting," it simply mirrored the State Office policy, and did not operational the State Office policy at the local level. The Facility should have policies and procedures that operationalize/define implementation of the parts of the State policy that are not specific. For this policy, examples include, but are not limited to the way in which community tours are managed, how educational	Noncompliance

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		activities are presented to individuals, expectations regarding staff training on the most integrated setting, how the Admissions and Placement Department staff ensure that all supports and services are included in CLDPs, the expectations regarding quality assurance efforts for this section at LBSSLC, and which staff are to review the CLDP prior to its submission to the Facility Director. 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. 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> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted in Section F, substantial compliance was not found for F1d, F2a1, and F2a3. As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by LBSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner.	Noncompliance

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		Identification of and Plans to Overcome Obstacles to Referral and Transition to Community Regarding referral at the individual level: b. Of the 10 ISPs reviewed, eight should have had obstacles to referral defined (the other two individuals, Individual #240 and Individual #97, were referred for transition to the community). For Individual #3, pages were missing from the ISP the Facility submitted, so this could not be determined. Of the remaining seven ISPs, two (14%) included an adequate list of obstacles to referral. (i.e., Individual #315, and Individual #214, both of whom the obstacle was LAR Choice, and as noted below, although this was accurate, the teams had not identified the specific reasons). The problems associated with the obstacles in the plans included the following: ▪ In some cases, obstacles or additional obstacles appeared to be present, but were not checked (e.g., Individual #109, LAR Choice was the only obstacle listed, but from the team's discussion, it appeared behavioral health also should have been checked; for Individual #20, no obstacles was checked, but she was not referred; and for Individual #7, only Behavioral Health Issues was checked, but clearly from the discussion LAR Choice also should have been identified). ▪ When guardians objected, adequate inquiry generally did not occur with regard to specifically what their concerns were (e.g., Individual #315, Individual #214). This is very important information to collect and analyze, but it did not appear it was being captured regularly; and ▪ For some individuals, the teams' justifications for identifying some obstacles were not clear (e.g., for Individual #139 and Individual #21, one of the obstacles was medical issues, but the specific medical issues/missing medical supports were not clearly defined). c. Of the one annual ISP meetings observed, an adequate list of obstacles to referral was identified for one (100%). Regarding a plan to address obstacles at the individual level: d. Of the seven ISPs, two (29%) (i.e., Individual #214 and Individual #139) included an action plan to address/overcome obstacles identified. Of these two, none (0%) were adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). Many examples are provided in previous reports of concerns related to these plans, and little change was seen in this most recent sample of ISPs. Often, plans were not included to address the obstacles identified. In other words, many individuals in the sample had generic plans to provide more educational opportunities (e.g., attend tour, participate in Provider Fairs), but these did not address the underlying obstacles (e.g., LAR Choice,	

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		Medical Issues, etc.). Generally, although plans were measurable, they were not individualized. QIDPs had participated in some training on developing individualized plans, but it was not clear what impact, if any, this had yet had. Based on interview with the Admissions and Placement Department staff, they recognized that the action plans related to obstacles needed improvement. Training for QIDPs had been scheduled for December 2013, but was cancelled. It was anticipated that the Admissions Placement Department would provide the rescheduled training to QIDPs soon. e. Of the one annual ISP meeting observed, a plan was included to address/overcome the identified obstacles for one (100%). Based on the discussion (as the actual written plan was not available at the time of the onsite review), one (100%) appeared adequate. The IDT for Individual #264 discussed in detail the need to provide his guardian with information about changes that had occurred since she last saw him, and options in the community that potentially could meet his needs. The IDT discussed the need for all team members to discuss with her the options, as well as to work with Individual #264 to increase his willingness to try new activities, ride on the van, etc. If these discussions resulted in written plans that were measurable, and showed the level of individualization that the team discussed, then they were adequate starting points. The IDT would need to continue to expand such efforts as time went along, if these were not successful, particularly because the team clearly believed that Individual #264 could be supported in a more integrated setting. Regarding transition at the individual level: f. Of the three CLDPs and related ISPAs reviewed, one (i.e., Individual #259) should have had obstacles to transition defined. Of this one CLDP and ISPA related to transition, none (0%) included an adequate list of obstacles to transition. For Individual #259, the ISPA was vague regarding specifically what the obstacles were (e.g., guardian appointed, and delay with home). g. For this one individual, none of the ISPAs (0%) had action plans to address the obstacle to transition. 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 QIDPs and team members on the State Office list of obstacles to transition, during interviews with Admissions Placement staff, they indicated that an obstacle to transition had been identified for one person, but not documented. 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	

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		them. 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. Preferences of individuals: h. Of the ten ISPs, one (10%) (i.e., Individual #240) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). i. Of the one annual ISP meeting observed, the individual's preference for where to live was adequately described in none (0%), and this preference appeared to have been determined in an adequate manner for none (0%). The team for Individual #264 did not yet have a good idea of what his preferences were. The team had some discussion about ways that they might learn more about his preferences. Preferences of LARs: j. Of the five ISPs for individuals with guardians, two (40%) included an adequate description of the LAR's preference and how that preference was determined by the IDT (i.e., Individual #7 and Individual #139, for whom the LARs' concerns were discussed in some detail). k. Of the one annual ISP meeting observed, the LAR's preference for living setting was adequately described in none (0%), and this preference appeared to have been determined in an adequate manner for none (0%). It was not clear that the LAR's preferences for Individual #264 had been determined through an informed consent process, during which the team had discussed the risks and benefits with the guardian. In fact, the team identified concerns about whether or not the guardian had current knowledge about Individual #264's current skills and abilities. 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 were generally 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 community placements to	<u>Individualized Plans</u> a. In reviewing 10 recently completed ISPs, two individuals (i.e., Individual #240, and Individual #97) had been referred for placement, and were engaged in the CLDP process. For the remaining eight, eight (100%) had a plan that addressed education about	Noncompliance

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	individuals and their families or guardians to enable them to make informed choices.	community options. Of these, none (0%) were adequate. Although they were measurable, none were individualized. Of note, in the Presentation Book, the Facility included the ISP for Individual #140 as an example of individualized action plans developed. Although this plan included some slightly more individualized steps, it did not set forth a plan in sufficient detail, did not include specifics about the types of activities that would provide education tailored to his needs and preferences, and certainly did not describe what appeared to be happening for Individual #140 according to discussions with the Transition Specialists. On a positive note, on 10/18/13, QIDPs participated in training on developing individualized action plans related to living options. Examples were provided, including an example of individualized community provider tour questions. However, it was not clear what impact, if any, this had yet had. 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. Many examples of concerns related to the plans have been discussed in previous reports, and little change was seen in this most recent sample of ISPs. As indicated in the Monitoring Team's previous reports, 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. <u>Provider Fair</u> b. The Facility had held a provider fair within the past 12 months. In fact, the Facility was now conducting two provider fairs each year. One was held on March 7, 2013, and another was held on September 15, 2013. According to information in the Presentation Book for Section T, prior to the most recent fair, one of the Local Authorities sent invitations to all of the local providers. A postcard was sent to all individuals'	

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		correspondents. An email was sent to all LBSSLC staff, and flyers were posted in the residences and other buildings on campus. The Transition Specialists obtained information from local providers and assembled a folder that individuals, staff, and family members could take with them. Several providers donated money, and t-shirts were made and distributed during the Provider Expo. Providers held a question and answer session. Seven providers, including 19 guests, were available to present information about their programs. Two of the guests were individuals that previously lived at LBSSLC, who were able to share their experiences with attendees. The Facility had measured and evaluated outcomes, and used the information to make changes for future fairs. As noted above, based on data the Facility provided, there were seven providers. According to information included in the Presentation Book, participants at the September 2013 fair included 68 individuals, six Legally Authorized Representatives, 22 direct support professionals, 63 "professional staff," and 19 provider staff/guests. Facility staff had graphed this data to show comparison across this most recent Provider Fair, and the last two fairs. Meeting minutes for the meeting Facility staff had with the Local Authority after the September 2013 event showed discussion of the data, including some ideas regarding aspects that went particularly well (e.g., the question and answer session that allowed LARs to ask questions), as well as some future ideas (e.g., a different provider evaluation). 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). <u>Local Authority</u> c. The Facility appeared to maintain good communication and a working relationship with the LA, participated in at least quarterly meetings with the LA (i.e., LBSSLC had monthly meetings with the LA), and ensured relevant topics were on the agenda for the LA meetings. Based on interview with staff and review of minutes, a group of Facility staff was meeting with Local Authority staff monthly. From the Facility, this generally included the Admissions Placement Coordinator, QIDP Coordinator, QIDP Educator, and Transition Specialists. Based on interview and review of the minutes, the group discussed upcoming CLOIP encounters, provider fairs, individuals in the process of transition, and different ways to offer individuals and their correspondents education about community living options (e.g., the Transition Specialists attending ISP meetings, when LARs were not comfortable with LA staff being present). <u>Tours of Community Providers</u> d. The Facility did not yet have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate,	

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		and identified all individuals and whether or not each went on a tour). Based on data the Facility provided, between 5/15/13 and 11/15/13, 12 community provider tours were conducted. The Facility was able to provide data on how many individuals attended these tours. For example, between 11/15/12 and 11/15/13, 58 individuals had attended tours, or approximately 29 percent of the individuals residing at LBSSLC. 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 above, such action plans often were not individualized, and so the appropriateness of the tours on which individuals participated could not be assessed. In addition, when asked for information to confirm that individuals that had an action plan to attend a community tour had gone on one, the Facility produced copies of action plans, but could not produce aggregate data to show how many individuals had attended tours as required in their ISPs. As a result, the Facility did not have an adequate system to track and manage tours, and the following metric could not be completed: e. Based on the Facility's own report, of the ____ individuals at the Facility for whom a tour was appropriate, ___ (%) went on a tour appropriate to their needs within the past year. Of note, although the Facility Self-Assessment provided some data, on educational opportunities, the data could not be interpreted or used to complete these indicators. Problems included: it was not clear what specifically was being measured (e.g., "opportunities given" was not defined), and when the Facility was asked through a separate document request to provide specific information related to the above indicators, the documentation submitted did not support the information included in the Self-Assessment. f. Of the six individuals in the sample for whom their teams had determined a tour was appropriate (i.e., Individual #97, Individual #20, Individual #21, Individual #3, Individual #7, and Individual #240), none (0%) went on a tour tailored to their needs within the past year. Although five of the six individuals had documentation that they went on a community tour (i.e., the one that did not was Individual #21, for whom documentation indicated a tour did not occur), there was no way to determine whether or not the tours were tailored to their needs. Their ISP action plans were not individualized, because they did not specify the types of homes, day or vocational programs, or services that it would be important for them to visit. In addition, monthly reviews and/or ISP narratives provided little to no information regarding the types of programs they visited and whether or not the visits were responsive to the individuals' specific needs and preferences.	

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		Visits to Friends in the Community g. The Facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. The Facility's documentation indicated that when individuals went on community exposure tours, they sometimes visited individuals that used to live at LBSSLC. In addition, an individual that had moved to the community invited four peers to the individual's home in the community. However, this was not evidence of a systematic process to identify individuals who would benefit, and assist in making it happen. Educational Activities at/by Facility for Individual h. Since the last onsite review, other educational activities for individuals did occur during self-advocacy meetings, did not occur during house meetings for individuals, did occur during family association meetings, and did occur during any other appropriate situations or locations. Some of the education that had occurred included: ▪ 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 directories to describe the services that all community providers in the area offered. ▪ The Admissions Placement Coordinator and/or Transition Specialists had continued to be involved with the Self-Advocacy Group. Based on information provided, in May, June, July, and August, the related topics covered were community exposure tours, a presentation from a community provider, and a PowerPoint presentation entitled: "Self Advocates Presentation." ▪ The Admissions Placement Coordinator also presented information to the Family Association, including through mailings, and at the Family Association meeting on 9/15/13, which was coordinated to fall on the same day as the Provider Fair. ▪ On 7/19/13 and 9/27/13, Transition Specialists visited individuals' residences to share the CLOIP DVD presentation. ▪ Between 5/24/13 and 11/1/13, eight Diner Discussions occurred. Transition Specialists shared the provider directory, and educational DVDs. In addition, they shared information about how to contact them. ▪ The Facility had another successful Most Integrated Setting Poster Contest that was initiated at the November 2013 Self Advocacy meeting. The entries were placed in The Diner on 12/4/13, and copies sent out to staff. Individuals and staff were encouraged to vote. The winning entries were announced at the December 2013 Self-Advocacy meeting, and an email also was sent. The winning posters were on display in the Administration Building. This provided a creative venue for individuals and staff to talk about various community options.	

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		Educational Activities for Staff The Facility was able to provide some information about staff participation in education activities related to community options. For example, the Facility provided data to show that between 11/15/12 and 11/15/13, 72 staff had participated in CLOIP tours. The Facility also provided information about how many medical staff had participated in some type of educational activity related to community options. In addition, the Facility reported that on 10/24/13, the Local Authority Living Options training was held, and approximately 99 staff, community provider representatives, and CLOIP staff participated in the training. The training included a presentation, and then community provider representatives rotated between tables of attendees to answer questions and provide information about the services they offer. The Facility Self-Assessment also included some information on staff educational opportunities, but it was not broken down according to the types of staff, or an in manner to show unduplicated counts. During upcoming reviews, the Facility will be asked to provide data for the following indicators: ▪ i. % of direct support professionals were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). ▪ j. __ % of clinicians were documented to have participated in one or more activities (e.g., in-service, workshop, community tour) ▪ k. ___ % of managers and administrators were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). l. Since the last onsite review, some information about successful community placements was shared with: a) individuals who were reluctant to consider community placement; and b) LARs who are reluctant to consider community placement. For example, at the Provider Fair, some individuals that had moved to the community from LBSSLC were present to share their experiences. However, more work was needed in this area. Such activities should be individualized, but some ideas would include: as appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; individuals who have experienced successful transitions could speak in other forums, such as at the Diner discussion; and newsletter articles could regularly highlight success stories. 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 needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. Staff educational opportunities related to the	

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		community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Expansion of efforts to share success stories was needed, particularly for individuals and guardians who were reluctant. 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. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. The most recent format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. a. Of the 10 ISPs reviewed, all of the assessments for two (20%) included the applicable statement/recommendation. Those individuals for whom all assessments included recommendations were Individual #214, and Individual #20. b. In five of the ten (50%) (i.e., Individual #97, Individual #Individual #20, Individual #7, Individual #3, and Individual #109) written ISPs reviewed, and during none of the one (0%) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. c. In none of the ten (0%) written ISPs reviewed, and during none of the one (0%) annual ISP meetings observed, a thorough discussion of living options occurred. For Individual #3, it appeared that pages were missing from the copy of the ISP the Facility provided to the Monitoring Team, so Individual #3 was removed from the sample for the indicators that follow. d. In eight of the remaining nine individuals' ISPs (89%), a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included. Individual #240's team did not make a clear recommendation to the individual. For Individual #240, the ISP indicated that many Facility discipline members recommended community transition, but psychiatry and psychology did not due to concerns that Individual #240's behaviors could result in criminal charges in the community. The team stated that there had been a similar lack of consensus last year, but through the review team process, the Facility Director had determined that a referral would be made. The team went on to continue the referral, despite the continuing lack of consensus. It was not clear why this lack of consensus was not again the subject of a review team process.	Noncompliance

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		e. In nine of the nine (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. However, for only two of the nine individuals (22%), adequate justification was provided for the team's recommendation (i.e., for Individual #214, and Individual #9). The following provide examples of the problems identified: ▪ For Individual #139, the team did not reconcile discrepancies between various team members' independent recommendations. For example, the dentist said he could be supported in the community, but other team members said he could not, and this difference of opinion was not reconciled. The team concluded that due to guardian choice and medical issues, Individual #139 should not be referred. Although the guardian's opposition was documented, the team did not explain in any detail its concerns about medical supports, or the specific supports it believed were not available. ▪ For Individual #97, the PCP and nurse had not recommended referral to the community. Although the recommendation of team members provided an explanation of how the PCP had changed her mind, no reconciliation of the nurse's recommendation was described. ▪ For Individual #21, based on the summary and review of the assessment, disciplines made varying recommendations, including some that indicated the individual could transition to the community, and others that did not. The team, absent the individual, recommended against transition, but no explanation was provided to reconcile the differences of opinions, or explain how a number of team members changed their minds. ▪ For Individual #315, the psychiatry assessment indicated: "Community placement is not recommended due to the history of episodic aggression." This recommendation was not reflected in the ISP, and it is unclear how this recommendation was reconciled with other team members' recommendations. ▪ For Individual #109, the team concluded that he could not be supported in the community despite the fact that five of 11 team members had indicated he could be served in the community. No documentation was found of how these five team members changed their minds, or how the team reached this consensus. ▪ For Individual #20, the team concluded that due to a change in her behavior, that included increased peer-to-peer aggression, a move was not recommended. It was explained that this change occurred after the disciplines made their recommendations in the assessments. What was not clear from the discussion was whether the team had considered that a smaller living environment might benefit Individual #20, whose preferences included: "quiet environment," and "being left alone." As the Monitoring Team had recommended, for some individuals for whom their teams believed transition would be appropriate "if appropriate supports were available," teams	

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		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. Anecdotally, the Transition Specialists shared examples of efforts to engage in such processes. Specifically, for one individual (i.e., Individual #140), a slow process of exploration was underway to allow identification of supports that would work for him, and to assure the LAR that the transition would be successful. From the description the Transition Specialists provided to the Monitor, this illustrated a very individualized approach that involved working carefully with Individual #140's team, guardian, and the community providers. It was resulting in a lengthier transition, and required commitment from a number of staff at the Facility and from the community provider agency. However, it likely will result in the provider having a clear understanding of Individual #140's needs, and the team and guardian having a good understanding of whether supports and services to meet his needs are in place, allowing tailoring of the CLDP to ensure his needs are met. It also was providing Individual #140 with the time he needed to develop relationships with staff in the new setting(s). These efforts were commendable, and should be expanded. For example, in reviewing the sample of ISPs, the Monitoring Team found that Individual #7's team included no steps to further identify the reasons or solutions to Individual #7's concerns about transitioning to the community, or action steps to identify providers that could support her significant behavioral issues. Individual #7 was an example of someone who likely would require a very individualized transition process (i.e., not the standard process of going on a couple of visits, picking a provider, doing a few visits, and moving). The individualized approach Transition Specialists were beginning to use likely would be beneficial for someone such as Individual #7. Teams generally were not having thorough discussions about community living options. Although Facility discipline members generally were making a specific recommendation independent of the individual and his/her guardian, problems continued with regard to teams documenting a well-supported justification for their decisions. 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	Since the Monitoring Team's last onsite review, five individuals had transitioned to the community. Three of these individuals' CLDPs were reviewed (i.e., Individual #259, Individual #79, and Individual #19). This represented 60% of the relevant CLDPs. Based	Noncompliance

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	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:	on review of these CLDPs: ▪ One of the three (33%) (i.e., Individual #19) CLDPs were initiated within 14 calendar days of referral. The initial meetings for the other two individuals were held past the 14-day timeline. ▪ None of the three (0%) CLDPs included documentation (e.g., ISPAs or other document) to show that they were updated throughout the transition planning process. Although all three teams met, there was no evidence that the teams regularly updated the CLDPs, particularly pre- and post-move required supports, based on what they had learned through the process of investigating community options for the individuals. The documentation included in the ISPAs related to selection of providers generally did not show that teams were using a draft list of pre- and post-move supports to determine the appropriateness of various providers and/or specific community options. More often, teams referenced the individual's reaction to specific sites. Although this was an important factor, it is essential that team also objectively determine whether or not the community provider can provide the protections, supports, and services the individual needs. This should not just be based on problems the individual might have experienced in the short time an overnight visit occurred, but the team should use the list of supports it has developed to assess the appropriateness of the proposed services. ▪ None of the three (0%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). Although all three showed that some members of teams met, and were involved in the process, none of the three individuals had all necessary team members sufficiently involved in the process. For example, for none of the three individuals was there documentation to show that direct support professionals were involved in the meetings related to decisions about the appropriateness of specific community providers or sites. In other instances, individuals clearly had behavioral issues or HT issues, and relevant staff were not involved in team meetings during which such issues were discussed. ▪ None of the three (0%) CLDPs or other transition documentation included documentation to show that the Facility worked collaboratively with the LA. Although the LA attended some pre-CLDP meetings, and attended the CLDP meetings, documentation did not clearly indicate what collaboration occurred. The Facility remained in noncompliance with this provision.	
	1. Specify the actions that need	a. The Community Living Discharge Plans reviewed included a number of action steps	Noncompliance

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	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.	related to the transition of the individuals to the community. Since the last review, the Facility appeared to have made efforts to include some more specific supports and services. However, none of the three CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the following six bullets occurred adequately and thoroughly: ▪ Training of community provider staff, including staff to be trained and level of training required: 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. However, the plans did not define which community provider staff needed to complete the training (e.g., day and residential staff). 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; ▪ Collaboration with community clinicians (e.g., psychologists, PCP, SLP): Missing from the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individuals (e.g., medical staff, nurses, therapists, psychologists, psychiatrists, etc.). For many individuals, including those in the sample for this review, this would be necessary to ensure ongoing coordination of care; ▪ Assessment of settings by SSLC clinicians (e.g., OT/PT): On a positive note, the ISPAs for Individual #19, documented the identification of the need for Behavioral Health Services staff to visit day programs prior to the individual visiting them to assess their ability to meet his needs. Subsequent ISPAs reported on the results of these visits. However, such supports were inconsistent across individuals, because both Individual #259 and Individual #79 had needs for which involvement of Behavioral Health Services and/or Habilitation Therapies staff should have been required, but was not. For example, for Individual #259, during one of the pre-move meetings: "HT staff stated that they would like to be able to see the home environment to ensure that it is a fit for [Individual #259's] needs before an overnight stay would occur." However, this was not written in as a pre-move required support, nor did the documentation provided show that such a visit had occurred; ▪ Collaboration between provider day and residential staff: No coordination was specified as needing to occur between current and future residential or day/vocational staff, and for the individuals reviewed, and for these individuals, this would have been an important component;	

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		▪ SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community); and ▪ Collaboration between Post-Move Monitor and Local Authority staff: 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. b. Three of the three CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. However, documentation was not included to show that the activities did indeed occur. The Facility remained out of compliance with this provision. Continuing problems were noted with regard to teams' definition and inclusion in CLDPs of comprehensive sets of specific steps that Facility staff would take to ensure smooth and safe transitions for the individuals moving to the community.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessments. Although the Facility had made progress with regard to obtaining timely assessments and some improvement was seen with some assessments, the quality (i.e., comprehensiveness) of most of the assessments was significantly lacking. More specifically: ▪ For none of the three CLDPs reviewed, all necessary assessments were completed. For none of the individuals had the PSI, FSA, or IRRF been updated to ensure that their preferences and needs, particularly their needs related to	Noncompliance

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		risk, were sufficiently addressed. ▪ For two of the three CLDPs reviewed (67%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For Individual #259, given the numerous differences in dates between the chart the Facility provided and the copies of the assessments, as well as the discrepancies noted on the chart, where dates the assessments were received were often before the dates of the assessments, the Monitoring Team could not determine with any certainty that the assessments had been timely completed. ▪ For two of the three CLDPs reviewed (67%), all assessments were available to the Admissions Placement Coordinator/Transition Specialist and IDT prior to the final CLDP meeting. For Individual #259, the discrepancies noted above called into question whether the assessments were available to the IDT in time for the final CLDP meeting. ▪ For none of the three CLDPs reviewed (0%), the assessments were of adequate quality. The following summarizes concerns and areas of some improvement: o 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. o On a positive note, some assessments had begun to include more detail regarding the protections, treatments, and supports that individuals needed (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.). Although this remained a work in progress, it was positive that some disciplines were beginning to include more detail. As discussed in further detail with regard to Section T.1.e, of significant concern was the fact that these more detailed recommendations were not being translated into necessary pre- and post-move required supports. o 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 need to be made to accommodate community settings that might	

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		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. o In addition to specific issues related to transition, as is discussed in other sections of this report, a number of the underlying assessments were not of adequate quality. o Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. The following specific information is repeated here from Section M to provide additional insight in concerns related to assessments. A review of the nursing documentation and Nursing Discharge Assessment Summaries for six individuals discharged/transitioning to the community (i.e., Individual #64, Individual #61, Individual #291, Individual #81, Individual #79, and Individual #19) found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. None of the IPNs were included in the document request that stated: "For the past six months, nursing documentation for individuals who have transitioned to the community, including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through	<u>Adequacy of Pre-Move and Post-Move Required Supports</u>	Noncompliance

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	the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDPs reviewed included pre-move and post-move required supports. Since the last review, some limited progress had been made. Admissions and Placement Department and Transition Specialist staff appeared to be 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 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. In addition, many supports were not measurable. 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 through assessment or during pre-move site visits, 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. a. In none of the three CLDPs reviewed (0%), a comprehensive set of pre- and post-move required supports was identified in measurable/observable terms. The Monitoring Team has provided many examples of concerns in previous reports. The Facility's CLDPs continued to have numerous missing supports. Focus should be placed on meeting the following standards: ▪ 1) <u>The list should be comprehensive and inclusive, demonstrated by</u>: o Sufficient attention should be paid to the individual's past history, and recent and current behavioral and psychiatric problems: ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting. For example, Individual #19 and Individual #79 had behavioral issues that could have required staff intervention, but not plan was articulated for what supports community providers would have in place should such behaviors occur after transition to the community; and	

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		▪ For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle. For the individuals in the sample, teams had identified some medical supports prior to transition, such as the name and first appointment dates for the PCP and psychiatrists. This was positive, however, other supports, such as involvement of community provider agency behavior analysts from the time of or before the transition were not included as supports, even when this appeared necessary (e.g., for Individual #79 with a number of target behaviors including pica, or Individual #19 that had a history of leaving without notifying staff). o All safety, medical, healthcare, therapeutic, risk, and supervision needs should be addressed: ▪ For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. All three individuals had risks that were not sufficiently addressed in the CLDPs; ▪ For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. Although for some of the health care indicators of the three individuals, supports had been included to measure them (e.g., constipation and weight), a number of such supports were missing, and parameter for reporting issues to health care staff were consistently missing); ▪ With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians. For all three individuals, such	

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		supports were consistently missing; ▪ In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community. For all three individuals, supports provided at the Facility were removed/not included in the CLDPs, and adequate justifications were consistently missing. "Justifications" indicating that the community PCP would make decisions about needed services or that such services would be discussed in training did not provide the team's rationale for the services no longer being required; and ▪ Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). For the three individuals, staffing supports were described as "24-hour awake" without any of the necessary definition. In addition, the team for Individual #79 did not include a support to address the individual's need at times for one-to-one staffing. o What was important to the individual should be captured in the list of pre-/post-move supports. As noted above, the PSI was not one of the assessments updated for the CLDPs, and for the sample of three individuals, there was no evidence such information was used to ensure that the individuals' preferences were consistently and meaningfully incorporated into CLDPs. Occasional references were made to preferred activities (e.g., being alone, having access to a recliner, etc.), but clear reference to what was important to the individual was generally missing. o The list of supports should address thoroughly the individual's need/desire for employment, and/or other meaningful day activities. ▪ Particular attention needs to be given to adequately	

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		defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component. For none of the three individuals was this level of detail provided. In fact, for all individuals a global statement such as: "will be enrolled in a day/habilitation program" was the only support included in relation to day/vocational supports. o Positive reinforcement, incentives, and/or other motivating components to an individual's success should be included in the list of pre-/post-move supports. Other than global supports related to involving individuals in preferred leisure activities, supports that integrated individualized positive reinforcement of incentives were missing from the three plans reviewed. o There should be pre-/post-move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. These were missing from all three plans. o There should be pre-/post-move supports for the provider's implementation of supports, including, for example, the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue: ▪ As appropriate, teams should identify as post-move supports the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications should be made to the methodology for providing these supports, with the end result being the individual's need for the support being met. Based on review of the three plans, sometimes PNMPs, dining plans, and PBSPs were referenced as needing to be implemented, but this was inconsistent. In addition, other plans that required implementation were not identified as post-move supports,	

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		such as nursing care plan or IHCPs; ▪ CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community. None of the three plans reviewed included such supports, and due to assessments that did not include all necessary components, it was not clear whether or not such action steps were needed; o All recommendations from assessments should be included, or if not, a rationale should be provided. For many recommendations for all three individuals, the CLDPs indicated that the teams had chosen not to include them as supports (e.g., OT/PT recommendations), and gave the rationale that the community PCP would make decisions, competency-based training would cover the need for staff to provide supports, and/or they would be addressed through part of his daily routine. These were all inadequate justifications, and resulted in numerous important post-move supports not be included in his CLDP. ▪ 2) <u>The wording of every pre-/post-move support should be in measurable, and observable terms</u>: Many problems were noted with regard to the lack of measurable supports for all three individual. For example, for Individual #259, some of the supports that were not measurable included: "will continue training to increase environmental awareness, important relationships, and greater independence," "will be provided opportunities for leisure and recreational activities," or " will be monitored for constipation." For Individual #79, a few examples of supports that were not measurable included: "strategies to encourage weight loss and exercise for [Individual #79] will be reviewed," or "will be provided opportunities for leisure and recreational activities." ▪ 3) <u>Every pre-/post-move support should include a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur</u>: Although some evidence was listed, due to issues related to measurability of the supports, it often was unclear for the three plans reviewed what the criterion were, or at what level/frequency/amount the supports should occur. Of note, the Facility provided documentation of a review that State Office had completed of Individual #291's CLDP. The correspondence from State Office indicated: "This is an excellent example of a CLDP. It contains enough information so that DSP [direct support professional] staff would have good information to provide necessary services. Supports and Services are well written and clear so that PMM [Post-Move Monitor] knows what to look for and where. This is one of the best I have seen." The Monitoring Team reviewed	

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		the CLDP, and disagrees with State Office's assessment. Although the narrative of the plan included some good descriptions of services the individual required and some of the recommendations from assessments were valuable in that they referenced important information about supports the individual required, much was missing from the narrative descriptions as well as the recommendations. In addition, all of the same problems noted above with regard to deficiencies in the pre- and post-move supports for the three sample CLDPs also were noted for those included in Individual #291's plan. Many supports were missing, and of significant concern, the team had not translated some of the good descriptions in the narrative related to supports the individual required and/or valuable recommendations in the assessments into pre- and post-move required supports. Instead, the team deferred most of the recommendation, saying instead the PCP in the community would address them, they would be covered in training, they were not necessary, etc. As just one example, the narrative description provided some valuable information about the nursing services being provided at the Facility and the direct support professionals' roles in addressing the individual's at-risk conditions, including necessary communication with nursing staff. The medical assessment appropriately recommended that nursing care be continued. However, the team documented: "It was agreed this recommendation would be addressed through a review of nursing documentation for [Individual #291's] various medical conditions and did not need to be formalized as a post-move support." As a result, the pre- and post-move supports reflected no nursing supports (i.e., intensity of nursing supports, qualifications of staff, clinical indicators to be monitored, nursing care plans to be developed/revised and/or implemented, parameters for direct support professionals to notify nursing staff of changes in status, etc.). The team's deferral of important recommendations and the omissions of supports throughout the CLDP, as well as State Office's commentary on the CLDP showed a lack of understanding of the development of a comprehensive set of pre- and post-move required supports in measurable/observable terms. In summary, since the last review, limited important improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. The CLDPs continued to be missing many necessary protections, services, and supports. <u>Essential supports In place on the day of the move</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	

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		pre-move site visit designed specifically to determine if the pre-move supports were in place. Based on a review of the Facility's pre-move monitoring documentation for the five individuals that moved since the Monitoring Team's last review (i.e., Individual #291, Individual #81, Individual #19, Individual #79, and Individual #259): ▪ b. For the five of five individuals (100%), a pre-move site review was conducted by the Facility. ▪ c. Of these five individuals' pre-move site reviews, five (100%) were done timely and completely. ▪ d. Of these five individuals' pre-move site reviews, five (100%) indicated that all of the essential supports were in place prior to the individual's move. ▪ e. The following indicator was not completed, because the Monitoring Team did not observe any pre-review site visits: For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly. Overall, a finding of noncompliance was made for this component of the Settlement 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.	a. There was not a written policy or written process for quality assurance to ensure the: a) development; and b) implementation of CLDPs. As discussed above, the Facility had adopted the State Office policy for the Most Integrated Setting. Although this had a brief section on quality assurance, it did not set forth the specific procedures that the Facility would use. Because the Facility had not developed a localized procedure, no further detail was provided in policy or procedures. As discussed with regard to Section E, the Facility did have overall QA procedures and a QA matrix that identified the monitoring that would be conducted for Section T. However, the matrix only listed the monitoring tool used to review the CLDP, and did not speak to other quality assurance efforts that were needed, such as the review of re-admissions, deaths, or other adverse outcomes that occurred after transition. b. Data were collected. However, the data being collected were not relevant and valid. In addition, the data were not being collected reliably. The QA Department had been conducting audits of CLDPs. However, the tool being used did not define the standards used, and did not result in valid findings. Inter-rater reliability had not been established between the QA Department and the Admissions Placement Department.	Noncompliance

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		Based on information in the Presentation Book for Section T, in early December 2013, the State Office had issued revised tools, and the Facility had begun implementing them. Reportedly, a process to establish inter-rater reliability was expected to occur. The Monitoring Team will provide more detailed comments on the revised tools at the time of the next review. However, of concern, based on the documents the Facility submitted, although these tools identified the methodologies (i.e., where to look for the information), no standards or guidelines were included to facilitate consistency between reviewers. c. Although the QA Department and Admissions Placement Department met monthly to review data, the data were not valid. The Facility's data showed 100% compliance with the development of CLDPs, which was not consistent with the Monitoring Team's findings. Until valid data is available, the following indicators cannot be assessed in any meaningful way: Data **were/were not** reviewed, summarized, and analyzed. Actions **were/were not** taken as a result of analysis of the data. The data **were/were not** included in the Facility's QA program. d. For none of the one individual (0%) (i.e., Individual #124) who returned to the Facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the Facility should be made. As a result of no actions being recommended in relation to the referral and transition process, the following indicators were not completed: Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). For Individual #124, a Special Review meeting was held after his return. The only recommendations resulting from the review related to supports that would be provided to the individual (e.g., counseling). The team did not critically review the CLDP or the transition process. As one example of concerns that the Special Review Team should have addressed, a major reason for his return was identified as the community provider's statement that: "they would be unable to manage him at the house without having to contact the police" due to the behaviors he was exhibiting. A critical question that the Special Review Team should have asked, but based on the documentation, had not was whether the CLDP included as pre- and post supports staff who were able to manage significant behavioral issues, including behaviors that might require physical intervention. Similarly, the team did not review the existence in the CLDP and/or the provider's implementation of any behavioral supports, such as involvement of an appropriately credentialed behavior analyst, communication between behavior analysts at the Facility and the community provider, etc. These are just a couple of examples of questions that should have been asked and answers to potentially improve the CLDP development and implementation processes in the future.	

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		e. At the time of the review, the following was not applicable, because no one that had transitioned to the community had died: ___ individuals that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the Facility should be made for ___ (%) of the cases. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for (%). f. Over the past year, of the nine individuals transitioned, three (33%) experienced one or more potentially negative outcomes since transition (i.e., Individual #2, who experienced an infection around the site of his PEG tube and went to the ER; Individual #64, who transferred sites twice based on his guardian's preferences; and Individual #124, who returned to the Facility). Of the two individuals not previously discussed, there was an adequate review conducted for none (0%) of the cases to determine if changes in the referral and transition planning processes at the Facility should be made. As a result, the following indicators were not assessed: Of these reviews, actions were recommended in cases. Of these ___ cases, actions were implemented for ___ (%). 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, including modifying, as appropriate, the monitoring tool to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, as valid monitoring results are obtained, 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. It is also essential that the Facility conduct critical reviews of the CLDP development and implementation processes for individuals that experience potentially negative 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	a. The Facility did not have an adequate system to collect information about obstacles to transition. The following summarizes concerns noted: ▪ Based on interview with Admissions Placement Department staff, one individual had an obstacle to transition, but it was not inputted into the system. ▪ In addition, it did not appear that the Facility had a process to collect information about obstacles to transition throughout the transition process. Such obstacles should include both issues that prevent transition as well as "compromises" to meeting the individual's needs and/or preferences as outlined by the IDT. Examples of compromises would include the individual "settles" for a day habilitation program because the vocational program that the team	Noncompliance

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	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.	recommended or that the individual preferred was not available in the part of the state in which the individual/guardian wanted to live; or the individual moved to an area of the state that was not the original preference because clinical services were not available close to family or in a part of the state that the individual preferred. It will be important as a system for collection of obstacles to transition is finalized to include these types of obstacles. On February 26, 2013, DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. In its last report, the Monitoring Team provided detailed comments on the Obstacles report, which explained both the positive aspects of this report, as well as the reasons for ongoing noncompliance. The annual obstacles report had not yet been updated since the time of the previous monitoring review, and, therefore, no new comments are provided here. As noted in the Monitoring Team's last report, improvements in data collection and analysis, implementation of revised ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained. During future reviews the following indicators will be assessed: ▪ b. The Facility **did/did not** have an annual narrative that showed it had: a) conducted a comprehensive assessment of obstacles; and b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. ▪ c. The State **did/did not** present an annual narrative that showed it had: a) conducted an analysis of the Facilities' data; b) taken 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; and c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature.	
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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing Facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for the seven individuals who had transitioned from LBSSLC to the community and for whom since the last review, the Post-Move Monitor had conducted post-move monitoring (i.e., Individual #64, Individual #61, Individual #291, Individual #81, Individual #19, Individual #259, and Individual #79). For these individuals during the time period reviewed, the LBSSLC Post-Move Monitor should have conducted 14 reviews. Of the 14 required visits, 14 (100%) had been documented as having been completed on time. <u>Visits to All Sites</u>	Noncompliance

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	supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	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 14 post-move monitoring reports, seven (50%) were completed thoroughly (i.e., those for Individual #81, Individual #19, and Individual #79). The following problems were noted: ▪ At the time of the last review, LBSSLC had just begun to use the original form from the Appendix of the Settlement Agreement that State Office was now requiring. This form was used for three of the individuals in the current sample (i.e., Individual #61, Individual #64, and Individual #291). 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 reviews using this form consistently failed to provide evidence of review for a number of pre- or post-move required supports. ▪ 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 #259, it was not clear which components of the PNMP were reviewed or how its implementation was assessed). 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 seven individuals reviewed, five of them had needs identified for follow-up to be conducted to ensure supports were implemented. The only individuals for whom no follow-up activity was required were Individual #61 and Individual #79. ▪ For four of the five individuals (80%), documentation was presented to show that adequate action had been taken. For Individual #81, no responses were recorded for "no" findings related to the need for a vocational program and implementation of her BSP. Although it was clear that efforts were being made to conduct thorough post-move monitoring, in order to ensure that findings are well supported and community providers respond to the findings, it is essential for the Post-Move Monitor to provide clear evidence in the reports. In addition, as the CLDPs continue to include more detailed	

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		protections, services, and supports, care will need to be taken to ensure that monitoring adequately confirms the existence of the supports. The Facility had made progress in documenting follow-up activities related to problems identified, but should continue to focus on providing follow-up for all identified concerns. The Facility remained out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on post-move monitoring visits for Individual #259, including to his day program, and home. During the reviews, the Post-Move Monitor systematically reviewed the supports included in Individual #259's CLDP. She asked many good questions, and reviewed documentation and conducted observations to support her findings. During the course of the previous post-move monitoring review for Individual #259, the Post-Move Monitor had identified some issues. During the review the Monitoring Team observed, the Post-Move Monitor followed up on the outcomes of actions the provider reportedly had taken to address the concerns. This included, for example, conducting observations to ensure that changes had been made to the home and that the day program offered Individual #259 more appropriate activities, and asking questions of staff to determine Individual #259's comfort level in his new home. Provider staff asked the Post-Move Monitor some questions about her findings, and the Post-Move Monitor responded professionally and clarified the provider staff's misunderstandings. The Post-Move Monitor explained to the Monitoring Team member that the following week, a meeting had been scheduled with the community provider team and the LBSSLC team to discuss the previously identified issues, and ensure that both teams were comfortable with the transition process, and the supports being provided to Individual #259. This showed good follow-up, and a commitment to ensuring Individual #259's transition was successful. Due to the thorough and accurate post-move monitoring observed, the Facility has been found in substantial compliance with this provision. It is important to understand that maintaining substantial compliance will require the Post-Move Monitor to keep pace with the expanded responsibilities for monitoring that will occur once CLDPs are improved.	Substantial Compliance
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		

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	period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the 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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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	pursuant to a court order vacating the commitment order.		

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 In response to request for curricula for training on the process used to determine functional capacity and prioritization of the needs of individuals, the following statement: "No curricula for training on the processes to determine functional capacity or to prioritize the needs of the individuals;" o Prioritized List of Those in Need of a Legally Authorized Representative (LAR), revised 11/14/13; o Prioritized List of Those in Need of a Legally Authorized Representative (LAR), revised 1/8/14; o New Guardians since May 2012; o Contact Log regarding guardianship from 5/15/13 through 11/15/13; o Addressing Prioritization at the ISP for Persons without Guardian, undated; o Settlement Agreement Compliance Report: Section U – Consent and inter-rater reliability information from May through October 2013; o LBSSLC Resident Satisfaction Survey; o Results of Resident Survey for September through October 2013; o Handouts from Guardianship Committee Meeting, on 1/9/14; o Presentation Book for Section U; o Self-Assessment for Section U, updated 12/20/13; and o Action Plans: Section U, updated 12/17/13. ▪ **Interviews with**: o Robin Seale, Assistant Director of Programs; o Carla Prell, Admissions Placement Coordinator; and o Christina De Los Santos, QIDP Educator. ▪ **Observations of:** o Guardianship Committee Meeting, on 1/9/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U, dated 12/20/13. 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 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, the Facility could not assess whether or not a functional capacity assessment/process had been implemented properly.

	○ The tool did not include instructions. For example, it did not describe methodologies to be used in conducting the reviews (e.g., which documents to review, observations to make, etc.), nor did it include standards to ensure that different reviewers consistently interpreted the indicators consistently. ○ In addition, it was not clear that the data collected through the use of this tool was consistently used in the Self-Assessment, and/or which monitoring tool was used to collect some of the data. For example, for Section U.1, data was provided regarding whether teams discussed the individuals' level of intellectual disability, psychiatric conditions, and communication abilities from a review of 20 ISPs. It was unclear what monitoring tool was used to collect this information, because no indicators related to these components of the ISP were included on the Section U monitoring tool. ○ Based on information provided in the minutes of the meetings between the QA Department and the Human Rights Officer, 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. However, different samples appeared to be used for different indicators, including 20 records for some indicators, and 48 records for other indicators. ○ The Self-Assessment did not consistently include percent sample sizes (e.g., the total number of ISP meetings held during the review period in comparison with the number of ISPs in the sample). ○ The staff responsible for this tool were the Human Rights Officer/Guardianship Coordinator and a Program Compliance Monitor assigned from the QA Department. ○ They had worked to establish inter-rater reliability. According to the Self-Assessment, inter-rater reliability was estimated to fluctuate between 80% and 95%. It appeared that when decreases were noted, the Program Compliance Monitor and QA Department attempted to identify the cause and make corrections. ▪ 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 in need of improvement. For these areas of need, the Facility Self-Assessment provided minimal analysis of the information. The Facility indicated that teams would participate in training on the use of the Individual Rights Assessment, but that a functional capacity assessment/process was needed for compliance to occur. 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. Staff reported that State Office had sought comments on a draft policy, and many comments were submitted. The lack of a process to assess an individual's functional capacity to render a decision regarding health or welfare continued to be a significant challenge to moving forward with this Section of the Settlement Agreement. 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. As noted in the last report, LBSSLC had begun to work with teams to identify current assessments that would assist in this process. Since the last review, the Human Rights Officer/Guardianship Coordinator had met with teams to discuss the use of some existing assessments, such as the psychological, psychiatric, and speech/communication assessments. As noted in the last report, 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 1/8/14, included names of 64 individuals served by LBSSLC. At the time of the review, Lubbock supported 202 individuals, of whom approximately 32% were estimated to need guardians, and 68% were identified as having 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, 20 individuals were in the Priority II category, and nine were in the Priority III category. In addition to reviewing the prioritized list, the Guardianship Committee provided ideas related to recruiting potential guardians and advocates, as well as funding guardianship costs. For example, the Guardianship Committee was working on a brochure to use in recruitment efforts, and discussed ideas for venues at which such a brochure could be used. 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 five individuals, with another eight 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. The Guardianship Committee had begun to develop some ideas for recruiting advocates and/or guardians for individuals who needed them. Although not a requirement of the Settlement Agreement, the Facility had taken some positive steps to

	increase individuals' ability to advocate for themselves. For example, efforts had been made to expand the Self-Advocacy group's activities to include more individuals on campus by bringing the activities to individuals that had more difficulty traveling to attend a meeting. In addition, a Resident Satisfaction Survey was in the process of being completed. This involved the HRO and Assistant Ombudsman visiting individuals on campus and conducting the survey with them, or if an individual could not communicate verbally, then completing the questionnaire with the assistance of a staff member that knew him/her well. The initial results of the survey showed concerns related to issues such as privacy, choice offerings, provision of needed services, and interactions with family and friends. Based on discussions with the Assistant Director of Programs, plans were being developed to address the findings from the survey. In addition, through some complaint investigations, including one complaint from an individual, the Facility was working to resolve some inappropriate use of rights restrictions that appeared to emanate from staff's misunderstandings of when such restrictions could be put into place and/or the need for individuals to be involved in decision-making and independent living activities.

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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. Staff reported that State Office had sought comments on a draft policy, and many comments were submitted. As indicated in the previous report, 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. The lack of a process to assess an individual's functional capacity to render a decision regarding health or welfare continued to be a significant challenge to moving forward with this Section of the Settlement Agreement. As noted previously, LBSSLC had continued its efforts to develop a prioritized list of individuals requiring guardians, and to identify guardians and pursue guardianship for individuals. However, an important first step was missing. Specifically, to determine individuals' ability to make informed decisions, the Facility continued to use the Rights Assessment, with occasional reference in some ISPs (e.g., Individual #97, and Individual #20) to other assessments such as the psychological assessments, and speech-language assessments. The Rights Assessments, with its related instructions, was inadequate to determine an individual's functional capacity to make decisions. And, the teams that used other assessments did not cite specific data or test results, and so provided no objective justification for their conclusions. One indicator of the problems with the current assessment process was that all individuals currently without guardians were on the prioritized list. It was unlikely that all individuals at the Facility needed guardians. For example, based on a review of ISPs, Individual #240 was identified as an individual for whom guardianship was being pursued. Although Individual #240 previously had a guardian, and, therefore, had been deemed by the court to require one, no assessment was submitted that showed	Noncompliance

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		whether or not limited guardianship would have been appropriate. Based on information included in the ISP and assessments, Individual #240 was a good example of someone for whom limited guardianship and supports to assist him with decision-making should at least have been considered. However, the team was pursuing guardianship without the benefit of an assessment that identified specific types of decisions that Individual #240 might be able to make with or without support. Since the last review, the Human Rights Officer/Guardianship Coordinator met with teams to train them to use existing assessments, such as psychology, psychiatry, and speech/communication, as well as to gather information from staff that know the individual best, as a mechanism for conducting the functional assessment the Settlement Agreement requires. As noted in the Monitoring Team's last report, these were certainly assessments that should be considered. In using such assessments, it would be important to summarize the information included in the assessments that spoke to functional capacity for decision-making (e.g., specific evaluation results, and test scores). In addition, a 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. 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. 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, which was mirrored in the State's policy, 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. Based on a review of the revised prioritization list and team sign-in sheets, since the last review, the HRO met with teams, and reviewed many individuals' priority levels. Based	

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		on these team reviews, some individuals' priority levels had shifted. It was not clear if the specific reasons for these shifts were documented in an ISPA or IPN, but if not, they should be. In addition, individuals that had moved to the community or died had been removed from the list. 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, and the Incident Management Review Team. Reportedly, as appropriate, changes were made to the prioritized list. The updated prioritized list, dated 1/8/14, included names of 64 individuals served by LBSSLC. At the time of the review, Lubbock supported 202 individuals, of whom approximately 32% were estimated to need guardians, and 68% had 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, 20 individuals were in the Priority II category, and nine were in the Priority III category. The Facility's Guardianship Committee continued to meet. Since the last review, additional efforts had been made to recruit more community members. Based on review of the minutes and observation of a meeting, one member was a former staff member that now worked for a community provider agency. Based on staff report, the volunteer paperwork was being finalized for a couple of other previous staff, as well as an individual that currently resided at the Facility. Based on review of the minutes and observation of the meeting held during the onsite review, the Guardianship Committee reviewed the prioritized list of individuals, and discussed and provided ideas related to recruiting potential guardians and advocates, as well as funding guardianship costs. As part of its Action Plan for Section U, the Facility was planning to identify other supports that might assist individuals to make decisions. The Action Plan indicated that this step had not yet been started. However, based on staff report, a focus had been placed on identifying individuals for whom an advocate might be an appropriate alternative and/or supplement. As discussed below, the Guardianship Committee was developing plans to assist with the recruitment of volunteer advocates. As indicated in previous reports, alternatives 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	

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		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 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 was continuing to make efforts to educate teams about current assessments that could be used as part of a process for determining functional capacity for decision-making. It also had a Guardianship Committee that reviewed the existing priority list, and updated the list based on input from teams.	
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	According to documentation and interview with staff, since the last review (i.e., July 2013), five individuals had guardians appointed. At the time of the review, potential guardians were in some stage of the process of identifying funding to complete the process or petitioning the court for guardianship for an additional eight individuals. As noted above, the list the Facility provided showed that a total of 64 individuals of the 202 individuals served by the Facility (32%) had been identified as needing guardians. LBSSLC had and continued to take a number of steps to attempt to identify guardians for	Noncompliance

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	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.	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. In addition, some previous employees had petitioned for and/or obtained guardianship for individuals at the Facility. Meeting minutes showed the Guardianship Committee was meeting quarterly. As noted above, the Guardianship Committee provided ideas related to recruiting potential guardians and advocates, as well as funding guardianship costs. For example, the Guardianship Committee was working on a brochure to use in recruitment efforts. At the meeting a member of the Monitoring Team observed, the Committee discussed a draft brochure as well as ideas for venues at which such a brochure could be used. Individuals for whom the costs of guardianship were challenging also were discussed. The meeting minutes also indicated that efforts were being made to have a presentation at a Committee meeting on the guardianship process in a community provider setting. A local guardianship agency also had provided a presentation. Staff reported that this agency's fees were too high for individuals LBSSLC supported. A concern that arose during the last review regarding the use of Facility staff as a resource for guardians for individuals LBSSLC supported had been resolved. Since the last review, this was determined to be conflict of interest. At the time of the review, one staff member was currently the guardian for an individual, but such relationships were no longer being pursued. 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 continued to be a valuable one for some of those interested in pursuing guardianship. Based on staff interview, since the last review, the Family Association had assisted three interested parties, and one application was pending. 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 for some eligible individuals. LBSSLC was not in compliance with this provision of the Settlement Agreement. Facility	

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		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 no revisions to the following LBSSLC Policies: ▪ Recordkeeping, revised 8/20/10; ▪ 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 management of records; o Active Record Order and Guidelines, revised 11/12/13; o Master Record Guidelines, revised 3/20/13; o Individual Notebook and Guidelines, revised 5/23/13; o Monitoring checklists for last 10 records reviewed, various dates; o Sample Corrective Action Compliance and Update Sheets, various dates; o Correspondence and documentation to confirm completion of plans of correction resulting from record audits, various dates; o Sample Recordkeeping quizzes, various dates; o Emails related to training on policies, various dates; o Reports for training on policies, various dates; o Direct Support Professional (DSP) training handouts for procedure training, various dates; o Procedure Training Completion Tracking Log, updated 1/7/14; o List of SSLC Policies and Local Procedures with date training was completed, updated 1/7/14; o Operating Procedures Manual Committee minutes, from June through December 2013; o Self-Assessment for Section V, updated 12/20/13; o Action Plans: Section V, updated 12/17/13; 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 12/20/13. 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 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, 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; Record Guidelines Monitoring with guidelines; and Settlement Agreement Section V: Recordkeeping and General Plan Implementation Section V.4: Use of Record in Pre ISP/ISP Meetings. 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 ISP Workgroup recently had determined that to assess the accuracy of the information in the records, discipline heads would complete audits of assessments. Audit tools were in the process of being developed for this purpose. 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 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 was tracking training of staff on new or revised policies. Although the Facility provided information to the Monitoring Team regarding numbers of staff trained for each policy, in the Self-Assessment, the Facility only included the numbers of policies recently issued for which training had been finalized/completed. Consideration should be given to including percentages of staff trained on policies (i.e., regardless whether or not the training is completed for 100% of staff). ▪ The Facility rated itself as being in substantial compliance with Section V.2, and in noncompliance with the remaining 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. The Facility

	identified or referenced in general terms that it had put action plans in place or planned to develop to address the negative findings.
	Summary of Monitor's Assessment: According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. 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. Since the last review, the Facility had taken steps to formalize the process for requesting corrective actions related to specific record reviews, and confirming that necessary steps had been taken. This process was in the initial phases of implementation. Next steps involved identifying issues that could be addressed either as a group (e.g., as opposed to retraining one staff member, training a group of staff on the same issue), or more systemically across the Facility. LBSSLC had a working system for policy and procedure development and the completion of related training. Specifically, over the last few review periods, the Facility had implemented a process to review and adopt State Office policies, and develop corresponding Facility procedures to operationalize the State Office policies as well as other procedures necessary for consistent implementation of the requirements of the Settlement Agreement. Naturally, over time, additional policies will be added, and/or revisions will be needed to current policies. The Operating Procedures Manual Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. This group also made decisions about training on policies and procedures. With the involvement of Competency, Training, and Development, the Facility had a working system to track staff's completion of the related training. 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 accuracy and completeness of the records, and the maintenance of complete data, continued to have the potential to impact negatively on teams' decision-making ability.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As noted in previous reports, a review of the LBSSLC policy on recordkeeping, revised in 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 Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at LBSSLC had Active Records, Individual Notebooks, and Master Records. Since the last review, the Facility had implemented a revised Table of Contents for the Active Records from State	Noncompliance

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		Office. This included modifying the names of assessments to be consistent with the recently revised assessment formats. ▪ 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 and/or monitoring 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. To further test staff knowledge, the Unified Records Coordinator conducted random quizzes of one to three staff members per month, and provided on-the-spot retraining for any incorrect answers. This data was not being aggregated, and shared with the QA/QI Council. ▪ 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. While the Monitoring Team was on site, the QA Department staff implemented a solution to an issue the Medical Director raised during the QA/QI Council meeting whereby the Medical Records Clerk entered the documents for the Medical Department into the tracking sheets. This showed quick attention to the concern raised. ▪ Based on staff interview, the Unified Records Coordinator continued to monitor staff's adherence to the check-out/check-in process. Reportedly, this process had resulted in improved security of the records, and records were available to people who needed access (e.g., for medical clinics, ISP meetings, etc.). ▪ According to the Provision Action Information, on 11/8/13, the QA Director and Director of Residential Services met to discuss the use of the Individual Notebooks and data collection. They "agreed that staff prefer to have the data collection forms in group books, dining books, etc., as opposed to having data collection forms in the Individual notebooks." As a result, the Individual Notebooks were not modified to include any additional data collection forms. Some forms, such as seizure reports and observation notes, remained on the Table of Contents of the Individual Notebooks. 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. As discussed in further detail with regard to Section V.3, the Facility had taken steps to formalize the	

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		process for requesting corrective actions related to record reviews. Specifically, requests for corrective action were sent to relevant staff, and documentation was requested to confirm that necessary steps had been taken to correct the immediate concerns, as appropriate (e.g., add a missing document to the record), as well as to prevent recurrence (e.g., retrain staff). Facility staff noted that even in the few months of implementation, some patterns were becoming apparent with regard to needed corrective actions. Next steps involved identifying issues that could be addressed either as a group (e.g., as opposed to retraining one staff member, training a group of staff on the same issue), or more systemically across the Facility. While the Facility had continued to make progress with regard to the quality of the active records, it was not yet in compliance with this provision of the Settlement Agreement.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	At the time of the review, based on the crosswalk the Facility provided, the Facility was awaiting policies from State Office for three of the 20 Sections of the Settlement Agreement. These included a final policy for Section G on Integrated Clinical Services, a final policy for Section H on Minimum Common Elements of Clinical Care, and a second policy for Section U to address the remaining components of the Settlement Agreement requirements related to consent. The Facility had developed a policy related to Integrated Clinical Services (i.e., specifically, the morning provider meeting and the related processes for integrating clinical services). This resulted in the Facility having policies in place for 18 out of 20 Sections of the Settlement Agreement (90%). The quality of these policies, any concerns regarding their content, and the status of their implementation are addressed in the various sections of this report. As noted in previous reports, the Facility had developed a process to review and revise policies, and determine which staff required training on policies, what level of training was required, and to track completion of the training. Since the last review, the Facility had made substantial progress in ensuring that local procedures had been developed to operationalize State Office policies, as well as to complete training for staff on the policies and procedures. The following summarizes the Facility's processes and progress: ▪ In April 2013, the policy on Developing/Revising Policy or Procedures was updated. It described the process for developing or revising policies, as well as providing training to staff on policies. It included: procedures for policies and procedures to be reviewed and updated whenever changes occurred, or at a minimum, policies and procedures needed to be reviewed every three years; when changes occurred, the Operating Procedures Manual Committee was to review them, and provide any necessary feedback; once policies were approved, the OPM was responsible for discussing and documenting staff training requirements (as discussed in further detail below); the QA Director was	Substantial Compliance

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		responsible for maintaining an updated Policy and Procedure Manual, including an online version on the shared drive, and notifying relevant department and discipline heads of new/revised policies and procedures and training requirements; the Competency, Training, and Development Department was responsible for tracking training, with department and discipline heads responsible for submitting training documentation; and when competency-based training was required, the QA Department was responsible for conducting monitoring for a sample of staff. ▪ As previously reported, the Operating Procedures Manual Committee met regularly (i.e., 12 times between July and December 2013) to review and approve policies and procedures. Based on review of minutes, as appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when recommendations had been addressed. Since the last review, the Facility had completed a substantial amount of work to ensure that the existing Operating Procedures Manual contained a comprehensive set of policies and procedures, as well as to remove older and/or unnecessary procedures. Based on review of the list of policies reviewed over the last year, which is not repeated here, the Facility was regularly reviewing and updating, as appropriate, policies and procedures related to the Settlement Agreement. The Facility had chosen to incorporate policies and procedures required by the Settlement Agreement into a Table of Contents that made sense from an operations and programmatic perspective (i.e., instead of labeling policies according to the Settlement Agreement sections, using headers related to training, continuity of services, health services, the IDT Process, Incident Management, etc.). This made sense for the long-term. ▪ The Facility had a process for determining training requirements for policies/procedures. The OPM Committee was 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, if applicable. o Since the last review, for many of the policies and procedures that had been developed or updated, the training had been appropriately identified as requiring staff review of the policies themselves with a face-to-face review with their supervisor, so that questions could be answered. For some of the more complex policies, classroom training was conducted (e.g., restraint). o For some of policies, the Committee had identified the need for materials to be developed specifically to facilitate direct support professionals' understanding of the key components for which they were responsible. The Facility provided three examples of these	

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		materials to the Monitoring Team. Review of them found that they generally were helpful in distilling complex policies into understandable summaries (e.g., at-risk individuals, and integrated planning). o In some instances, competency-based training was necessary. Based on review of the minutes, this need appeared to have been addressed appropriately. For example, in October 2013, the Committee reviewed the Lifting and Transferring of Individuals procedure. Appropriately, in addition to the review of materials, the Committee determined that competency-based training was necessary, and identified the mechanisms through which such training would be provided, including New Employee Orientation and refresher competency-based training, and Habilitation Therapies monitoring. ▪ The Facility had a system for communicating to relevant staff when policies/procedures were approved, and what the training requirements were. Based on a review of the correspondence the QA Director 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. ▪ The Facility had a process for tracking the training completed and sending reminders when training was overdue. As noted in the last report, the Competency Training Department (CTD) had developed and implemented a system to track the completion of training on each of the new/revised policies/procedures. As a result, the Facility was able to provide numbers of staff requiring training, as well as numbers of staff that had completed or still required training. o Based on a review of a sample of data the Facility provided for recently issued policies and procedures, training had been consistently documented for required staff, and when training was outstanding, correspondence was sent to relevant supervisors to request that training occur. o The Facility maintained a Procedure Training Completion Tracking Log. According to the log, since the Monitoring Team's last review, 45 policies and procedures had required staff training. At the time of the review, the due dates for five of these had not yet passed, leaving 40 for which training should have been completed. Of these 40, training had been finalized for 27. For the remaining 13, the Facility documentation indicated how many staff still required the training. Based on review of the logs CTD maintained, the number of staff, as well as the specific staff that required training were easily identified. The logs included staff that were out on extended leave (e.g., Family and Medical Leave), which allowed identification of staff that would need to complete training	

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		upon their return. Review of email correspondence illustrated that for outstanding training reminders had been sent to managers/discipline heads requesting follow-up. o During the onsite review, the Monitoring Team requested that the Facility provide an update on the status of the training for each of the Sections of the Settlement Agreement. The Facility submitted an updated version of the List of SSLC Policies and Local Procedures, dated 1/7/14. The Facility added a training column to the list. According to this document, for four Sections of the Settlement Agreement (i.e., Sections C, N, U, and V), training occurred before the Facility had the current tracking system in place. For the remaining 16 Sections, training had been completed and tracking information was available for 11 (i.e., Sections D, E, G, J, K, L, O, P, R, S, and T), training was in process for four (i.e., Sections F, I, M, and Q), and as noted above, a State Office policy did not yet exist for Section H. Additional policies also were needed from State Office on Sections G and U. As noted above, for any of the policies/procedures for which training had been conducted since the implementation of the current tracking process, the Facility could provide a list of staff trained, those that had been trained, or the number or a list of those staff that still required training. Such information could be translated into a percentage of staff trained for any of the policies/procedures. In summary, the Facility had a working system for policy and procedure development and the completion of related training. Specifically, the Facility had implemented a process to review and adopt State Office policies, and develop corresponding Facility procedures to operationalize the State Office policies as well as other procedures necessary for consistent implementation of the requirements of the Settlement Agreement. Naturally, over time, additional policies will be added, and/or revisions will be needed to current policies. The OPM Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. As noted above, the quality or completeness of the policies, as well as the full implementation of the policies/procedures are not addressed with regard to Section V.2, but rather in other sections of this report. The OPM Committee also made decisions about training on policies and procedures. With the involvement of CTD, the Facility had a working system to track staff's completion of the related training. As a result of the existence and consistent implementation of this system, the Facility was found to be in substantial compliance with this provision.	
V3	Commencing within six months of the Effective Date hereof and with	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included:	Noncompliance

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	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.	▪ Based on documentation submitted, the Unified Records Coordinator was completing at least five record audits per month. As indicated in the last report, after establishing inter-rater reliability between the Unified Records Coordinator and Lead File Clerk, the Lead File Clerk stopped completing regular reviews of records, but was available as a back-up auditor. ▪ As previously reported, LBSSLC continued using the monitoring review tool the State Office developed entitled Recordkeeping and General Plan Implementation for Sections V.1, V.3, and V.4. For monitoring records, the Facility continued to use its own review tool, entitled "Records Guidelines Monitoring," and the results were then reflected on the State Office tool. This data was then graphed by question on the tool. Based on review of data for September and October 2013, consistent problems were seen in such areas as the completeness, accuracy, and currency of information in the records. ▪ Since the last review, the Facility began using a monitoring tool entitled: "Settlement Agreement Section V: Recordkeeping and General Plan Implementation Section V.4: Use of Record in Pre ISP/ISP Meetings." On a monthly basis, the Unified Records Coordinator attended a sample of five ISP Preparation meetings and then, 90 days later, attended the ISP meetings for the same individuals. These also were the records that the Unified Records Coordinator reviewed the following month, when it was expected the ISP document would be completed. In addition to interviewing staff at the ISP meeting, the Unified Records Coordinator observed the team's use of the record in decision-making. This was a good addition to the Facility's efforts to ensure that the records were useful to team members, and that teams used the records meaningfully in their decision-making processes. As is discussed with regard to Section V.4, based on the Monitoring Team's observations of ISP meetings, there continued to be times when teams should have referenced the records and specific data within the records (e.g., when discussing PBSPs or SAPs), but they did not. The monitoring forms the Facility submitted generally provided positive examples of the use of the records, and generally did not note concerns about teams' use of data within the records. If/when this monitoring process were to identify problems with the teams' use of the records in the ISP process, if any, it would be helpful if the Unified Records Coordinator documented such issues on the forms, and that, as appropriate, actions were taken to address such issues. If no problems were noted, then it would be important to specifically state this on the monitoring form. ▪ The Facility also had determined that some additional monitoring was necessary. Specifically: o The Unified Records Coordinator continued to complete a review of the check-in/check-out sheets for records. As noted in the last report,	

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		based on this monitoring, the Facility had determined the need to reinforce these requirements with staff, which was done in March 2013. At the time of this most recent review, staff reported improvements with this process. o The Facility continued to track the timeliness of filing using the Document Submission Tracking log. A sample of pages of the log was reviewed to determine an average rate of filing the documents within three business days. According to the data from August through October 2013, an average of 97% of documents were filed within this timeframe, with a range of 93% to 100% over the three months. ▪ Since the Monitoring Team's last review, to address issues identified through regular record reviews, the Facility had developed, and on October 31, 2013, begun to implement an improved process for notifying staff of the need to take specific corrective actions in relation to individuals' records. Previously, the form only allowed a certain number of charters to describe the issue, so the form was being supplemented with emails. Since the last review, the Facility had begun to use the Corrective Action Compliance and Update Sheet. This form provided space to identify the tab in the record, or the document for which a concern was identified; the guideline that was not in compliance; the specific deficiency; the responsible person; the corrective action needed; the date(s) of reminder email(s) sent, if any; and the completion date. The Facility submitted some examples of completed forms, which showed detailed information, and identification of what appeared to be appropriate recommended corrective actions. In terms of the completion of corrective actions that the Records Department requested, documentation showed that many of even the initial requests were pending. The Unified Records Coordinator had followed up with reminder emails. For some of the actions that had been completed, for example, staff training, documentation was presented to show it had occurred. Facility staff recognized this was a new process, and it would take some time for follow-up to occur more timely. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, a system was now in place to request and track corrective actions resulting from individual record reviews. The process for completing corrective actions had had a slow start, but the Unified Records Coordinator had a system in place to send reminder emails if the deadlines for completing actions were not met. It was anticipated that over time, improvements would be seen in the timeliness of responses. In addition, the Unified Records Coordinator discussed the possibility of grouping similar corrective actions (e.g., several staff requiring the same refresher training) to streamline the process and make it more efficient. This made sense in terms of the best use of time.	

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		▪ The Facility recognized that a 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 potentially developing systemic corrective actions, as appropriate, to address them. Related action steps were included in LBSSLC's Action Plan for Section V. The Facility included the important step of monitoring the effectiveness of corrective action plans, and modifying them, as necessary. Although progress continued to be made with regard to this provision of the Settlement Agreement, LBSSLC was still in the process of implementing its system to make needed changes based on individual record reviews, 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.	As noted in the last report, 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 incorporated some, but not 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**: LBSSLC was monitoring some components of this, but not yet self-assessing all components: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted in the Monitoring Team's previous 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 continued to appear to be 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. Based on data from the Facility, from August through October, the average rate of filing documents within three days of submission was 97%. However, as the Facility's monitoring activities showed, some issues continued to exist with the timely availability of documents in Active Records. More specifically, the Facility's data showed that for four out of 30 records (13%) reviewed between May and October 2013, documents were	Noncompliance

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		current. This possibly was due to documents not being submitted timely for filing, or not being completed timely. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. As noted with regard to Section V.1, LBSSLC had a system in place to check that records were signed-out and signed-in, and to take action to find any unaccounted for records. o During the Monitoring Team's last review, some issues were identified with regard to filing Acute Nursing Care Plans. Documentation was submitted to show the Facility had worked to address the need for the timely filing of these documents to facilitate the provision of adequate clinical care. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: o In an effort to ensure the accuracy of data and other information in the records, the ISP Workgroup developed an outline for an Assessment Quality Checklist for assessments completed for the annual ISP meeting. At the time of the onsite review, discipline leads had been assigned the task of individualizing the checklist for their assessments. It was anticipated that once the audit forms were finalized, discipline leads would review the assessments for the five records that the Unified Records Coordinator reviewed each month, and data related to the quality of the assessments would be included in data related to the accuracy of the records. 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. As discussed with regard to Section S.3.a of the Settlement Agreement, based on the review of the sampled raw data sheets for SAPs, significant concerns remained with regard to the adequacy of data collection and, consequently, the effectiveness of ongoing monitoring of skill acquisition programming. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** As discussed in further detail with regard to Section V.3, the Facility continued to interview staff to determine how they used records in making decisions. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** In April 2013, the LBSSLC Unified Records Coordinator began attending five ISP Preparation meetings per month,	

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		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 and review of documents: o At ISP meetings during the week of the Monitoring Team's review, the records were available and at times, teams sometimes 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 were still missing. Data frequently was not discussed with regard to other aspects of care, such as PBSPs or skill acquisition programs. o The monitoring forms the Facility submitted generally provided positive examples of the use of the records, and generally did not note concerns about teams' use of data within the records. If/when this monitoring process were to identify problems with the teams' use of the records in the ISP process, if any, it would be helpful if the Unified Records Coordinator documented such issues on the forms, and that, as appropriate, actions were taken to address such issues. If no problems were noted, then it would be important to specifically state this on the monitoring form. 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
ASHA	American Speech-Language and Hearing Association
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
COS	Change of Status
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
DRI	Dietary Reference Intake
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
FSPI	Facility Support Performance Indicators
FTE	Full-time Equivalent
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
ID	Identification
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
IU	International Unit
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
QIDP	Qualified Intellectual Disabilities Professional
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
TOR	Treatment Observation Record
TSHA	Texas Speech Language Hearing Association
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UAD	Unauthorized Departures
UGI	Upper Gastrointestinal
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